

**TUFTS MEDICARE COMPLEMENT
EVIDENCE OF COVERAGE**

EFFECTIVE JULY 1, 2016





This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance. However, **Medicare is a plan that meets MCC standards. Because you have Medicare Part A and Part B, you meet MCC standards.**

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents 18 and older must have health coverage that meets the Minimum Creditable Coverage (MCC) standards set by the Commonwealth Health Insurance Connector, unless the health insurance requirement is waived based on affordability or individual hardship. For more information call the Connector at 877-MA-ENROLL or visit the Connector website (mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and does not meet MCC standards, even if it does include services that are not available in the insured's other health plans. However, **Medicare is a plan that meets MCC standards. Because you have Medicare Part A and Part B, you meet Minimum Creditable Coverage standards.**

If you have questions about this notice, you may contact the Division of Insurance by calling 617-527794 or visiting its website at mass.gov/doi.

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN

705 Mount Auburn Street
Watertown, Massachusetts 02472-1508

Hours:

Monday through Thursday from 8:00 a.m. to 7:00 p.m. (E.T.)
Friday from 8:00 a.m. to 6:00 p.m. (E.T.)

IMPORTANT PHONE NUMBERS

Emergency Care

If you are experiencing an *Emergency*, you should seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. Massachusetts provides a 911 *Emergency* response system throughout the state. If 911 services are not available in your area, ask your local telephone company about *Emergency* access numbers.

Member Services Department

For general questions, benefit questions, and information about eligibility for enrollment and billing, call the Member Services Department at 800-870-9488.

Medicare

Contact your local Social Security office or visit medicare.gov.

Mental Health Services

For assistance finding mental health professionals in your area, call the Mental Health department at 800-208-9565.

Services for Hearing Impaired Members

If you are hearing impaired, *Tufts Health Plan* (“*Tufts HP*” or “the *Plan*”) provides the following services:

- Telecommunications Device for the Deaf (TDD): 800-868-5850
- Massachusetts Relay (MassRelay): 800-720-3480

Coordination of benefits and worker’s compensation

For questions about coordination of benefits (how *Tufts HP* coordinates its coverage with other health care coverage you may have) and workers’ compensation, see Chapter 6 or call the Liability and Recovery Department at 888-880-8699, ext. 21098. The Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and 10:00 a.m. – 6:00 p.m. on Fridays.

Subrogation

Subrogation may occur if your illness or injury (such as injuries from an auto accident) was caused by someone else. For questions about subrogation, call Member Services or see Chapter 6.

Note: Italicized words are defined in Appendix A.

***Tufts Health Plan* Address and Telephone Directory, Continued**

IMPORTANT ADDRESSES

Appeals and Grievances Department

If you need to call *Tufts Health Plan* about a concern or appeal, contact Member Services at 800-870-9488. To submit your appeal or grievance in writing, send your letter to:

**Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02479193**

Website

For more information about *Tufts Health Plan* and the self-service options that are available to you, please see the *Tufts Health Plan* website at [**tufts-healthplan.com**](http://tufts-healthplan.com).

Tufts Health Plan Address and Telephone Directory, Continued

Translating services for over 200 languages For no cost translation in **English**, call the number on your ID card.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.

Gujarati વિના ખર્ચે ગુજરાતીમાં અનુવાદ માટે, આપના આઈડી કાર્ડમાં દર્શાવેલ નંબર પર કોલ કરો.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Hindi हिन्दी में बिना मूल्य अनुवाद के लिए, अपने आईडी कार्ड पर दिये गए नंबर पर कॉल करें।

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Khmer សម្រាប់សេវាកម្រិតដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើកាតសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາແບ້ນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo b33h il7n7 da Din4 k'ehj7 1ln4ehgo, hodiilnih b44sh bee han7'4 bee n44 ho'd7lzingo nantin7g77 bik11'.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

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Chapter 1

How Your HMO Plan Works

Overview

Introduction Welcome to the *Tufts Health Plan* Medicare Complement Plan (“TMC Plan”). We are pleased you have chosen us and look forward to working with you to help meet your health care needs.

Your satisfaction with *Tufts Health Plan* is important to us. If at any time you have questions, please call Member Services at 800-870-9488 and we will be happy to help you.

The Tufts Medicare Complement Plan The TMC Plan is designed to add to your Medicare Parts A and B coverage, subject to the terms, conditions, exclusions and limitations of Medicare eligible services. The *Plan* and Medicare together offer a comprehensive package of medical benefits.

Under the TMC *Plan*, coverage is provided for certain services that are not covered under Medicare Parts A and B. Those services include:

- Certain preventive care services, annual vision and hearing screenings; and
- Prescription drug coverage.

Eligibility for Benefits under this Plan

You have chosen to participate in a managed health care network in which you and your *Primary Care Provider* (“PCP”) play the most important roles. *Tufts Health Plan* Medicare Complement Plan is a health maintenance organization, which arranges for your health care through a network of health care professionals and hospitals. When you join the *Plan*, you will need to choose a *Primary Care Provider* (“PCP”) to manage your care. A *PCP* provides most of your routine care and keeps track of your health history, so he or she can recommend other doctors when you need specialty care. *PCPs* can also advocate for your health and help you get the care you need.

By joining the TMC Plan, you agree to receive your care from *Plan Providers*. If you fail to do this, this plan will not provide benefits for either Medicare-eligible services or the additional *Covered Services* available under this plan – so you will be responsible for any Medicare Part A and B *Deductible* and *Coinsurance* amounts.

The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

Note: Italicized words are defined in Appendix A.

Overview, Continued

Evidence of Coverage This book is your *Evidence of Coverage* and will help you find answers to your questions about *Plan* benefits. The *Plan* certifies that you have the right to the *Medically Necessary* services and supplies described in this *Evidence of Coverage*, provided they are authorized by your *PCP*.

The benefits described in this *Evidence of Coverage* are available as established by Massachusetts General Law Chapter 176G.

Under the Tufts Medicare Complement Plan, Medicare is the **primary insurer** and the *Plan* is the **secondary insurer**. Typically this means that Medicare pays its portion of expenses for covered services first, and the *Plan* then covers your Medicare Part A and B *Deductibles* and/or *Coinsurance*.

Coverage is subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original Medicare Plan. Coverage is subject to change per Medicare's guidelines. This *Evidence of Coverage* is not a full explanation of your Medicare benefits. You can learn more about Medicare by:

- Contacting your local Social Security office; or
- Visiting the official Medicare website at medicare.gov.

This TMC Plan covers all services that are covered under Medicare Parts A and B, even if they are not specifically listed in this *Evidence of Coverage*. You must receive services from *Plan Providers* for coverage.

In addition, please refer to your Medicare Handbook for any questions pertaining to the Medicare portion of your health care under this TMC Plan.

Please note that words with special meanings appear as italicized words in this *Evidence of Coverage*. Those words are defined in the Glossary in Appendix A.

Member Services Your satisfaction with the Tufts Medicare Complement Plan is important to us. The **Member Services Department** is committed to excellent service, and we are happy to help you. If you have any questions, please call the Member Services Department at 800-870-9488.

Calls to the Member Services Department may be monitored by supervisors to assure quality service.

How this TMC Plan Works

Primary Care Providers Each *Member* must choose a *Primary Care Provider (PCP)* who will provide or authorize care. If you do not choose a *PCP*, the *Plan* will not pay for any services or supplies except for *Emergency* care.

Medically Necessary services and supplies The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*.
Important: The *Plan* will not pay for services or supplies that are not *Covered Services*, even if they were provided or authorized by your *PCP*.

The Plan's Service Area In most cases, you must receive your care in the *Service Area*. The exceptions are for an *Emergency*, or *Urgent Care* while traveling outside of the *Service Area*.

For information about the *Service Area*, see the *Directory of Health Care Providers* or contact *Member Services*.

Changes to the Plan's Provider network The *Plan* offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. Although the *Plan* works to ensure the continued availability of *Plan Providers*, the *Plan's* network may change during the year.

This can happen for many reasons, including a *Provider's* retirement or relocation outside of the *Service Area*, or his or her failure to meet the *Plan's* credentialing standards. In addition, because *Providers* are independent contractors, they may leave the network if the *Plan* and the *Provider* cannot agree on a contract.

If you have any questions about the availability of a *Provider*, please call *Member Services* at 800-870-9488.

How This TMC Plan Works, Continued

Comparison of coverage The table below tells you if coverage exists, depending on the type of care you receive and the place you receive care.

IF you...	AND you are...	THEN you are ...
Receive routine health care services	in the <i>Service Area</i>	covered, if you receive care through your <i>PCP</i>
	outside the <i>Service Area</i>	<u>not</u> covered
Are ill or injured	in the <i>Service Area</i>	covered, if you receive care through your <i>PCP</i>
	outside the <i>Service Area</i>	covered for <i>Urgent Care</i>
Have an <i>Emergency</i>	in the <i>Service Area</i>	covered
	outside the <i>Service Area</i>	covered

Continuity of Care

If you are an existing Member

If your *PCP* disenrolls from the *Plan*, we will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your *PCP* for up to 30 days after the disenrollment in the following circumstances:

- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- Terminal Illness. If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

To choose a new *PCP*, call Member Services at 800-870-9488 or visit tuftshealthplan.com.

If you are enrolling as a new Member

If your *Provider* is not included in one of the *Group Insurance Commission's* health plans at the time of your enrollment as a new *Member*, you may continue to see him or her if:

- Undergoing Treatment/PCP. If you are undergoing a course of treatment, or the *Provider* is your *PCP*, you may continue to see your *Provider* for up to 30 days from your *Effective Date*.
- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- Terminal Illness. If you are terminally ill, you may continue to see your *Provider* as long as necessary.

To find a *Plan* *Provider*, call Member Services at 800-870-9488 or visit tuftshealthplan.com.

Conditions for coverage of continued treatment

As a condition for coverage of continued treatment, the *Plan* may require your *Provider* to agree to:

- Accept reimbursement from the *Plan* at the rates applicable prior to notice of disenrollment as payment in full, and not to impose *Member* cost sharing in an amount exceeding the cost sharing that could have been imposed prior to the *Provider's* disenrollment;
- Adhere to the quality assurance standards of the *Plan*, and to provide the *Plan* with any necessary medical information; and
- Adhere to the *Plan* policies and procedures, including those regarding referrals, prior authorization, and providing services pursuant to a treatment plan approved by the *Plan*.

About Your *Primary Care Provider*

Importance of choosing a *PCP*

Each *Member* must choose a *PCP* when he or she enrolls. You are eligible for all *Covered Services* once you have chosen a *PCP*.

The *PCP* you choose will be associated with a specific *Provider Unit*. This means that you will usually receive *Covered Services* from health care professionals and facilities associated with that *Provider Unit*.

IMPORTANT NOTE:

Until you have chosen a *PCP*, **ONLY** *Emergency* care is covered by *Tufts Health Plan*.

What a *PCP* does

A *PCP*:

- Provides routine health care (including routine physical examinations)
 - Coordinates your care and provides referrals for specialty services, as needed
- Note:** Your *PCP* does not provide referrals for inpatient and intermediate mental health services. See page 46 for information about obtaining referrals for these services.
- Offers coverage (from your *PCP* or a *Covering Physician*) 24 hours a day, seven days a week

Choosing a *PCP*

You must choose a *PCP* from the list of *PCPs* in the *Directory of Health Care Providers*. If you do not have a physician or your physician is not listed in the *Directory of Health Care Providers*, call Member Services at 800-870-9488 for help in choosing a *PCP*. You may also view the *Directory* online at tuftshealthplan.com/gic.

Notes:

- As required by law, under certain circumstances (such as pregnancy or terminal illness) you will be covered for services provided by your physician, even if he or she is not in the *Tufts Health Plan* network. Please see “Continuity of Care” on page 12 or call Member Services at 800-870-9488 for more information.
- The **Massachusetts Board of Registration in Medicine** provides information about physicians licensed to practice in Massachusetts. For additional information about a *PCP* or specialist, call the Board of Registration at 800-377-0550 or visit mass.gov/massmedboard.

Contacting your new *PCP*

If you have chosen a new physician as your *PCP*, you should contact your new *PCP*, and identify yourself as a new *Plan Member*. This is a good time to schedule an appointment for a check-up or any other care you need. Be sure to ask your previous physician to transfer your medical records to your new *PCP*.

About Your *Primary Care Provider*, Continued

If you can't reach your PCP

Sometimes you may not be able to reach your *PCP* by phone right away. The table below explains what you should do if this happens.

IF...	THEN...
Your <i>PCP</i> cannot immediately take your call on a weekday	Always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call. If your call is not returned on a weekday, please call Member Services at 800-870-9488 .
You need medical services after hours or on a weekend	Please contact your <i>PCP</i> or a <i>Covering Physician</i> . Your <i>PCP</i> , or a <i>Covering Physician</i> , is available 24 hours a day, 7 days a week. If you need <i>Inpatient</i> mental health or substance use disorder services after hours, please call 800-208-9565 for assistance.

Note: If you are experiencing a medical *emergency*, call 911 or proceed to the nearest emergency medical facility for treatment. You do not have to contact your *PCP* or a *Covering Physician*; instead, (see “When You Need *Emergency* or *Urgent Care*” below for more information).

Changing your PCP

You may change your *PCP* or, in certain instances, the *Plan* may require you to do so. The new physician will not be considered your *PCP* until:
 You choose a new *PCP* from the *Directory of Health Care Providers*;
 You report your choice to Member Services at 800-870-9488; and
 The *Plan* approves the change in your *PCP*.

Then, the *Plan* will send you a new Member ID card listing your new *PCP*.

Note: You may not change your *PCP* while you are an *Inpatient* or in a partial hospitalization program.

Canceling appointments

If you must cancel an appointment with any *Provider*.
 Always provide as much notice to the *Provider* as possible (at least 24 hours), and
 If your *Provider's* office charges for missed appointments that you did not cancel in advance, the *Plan* will not pay for the charges.

About Your *Primary Care Provider*, Continued

Referrals for specialty services

Every *PCP* is associated with a specific *Provider Unit* (as defined in Appendix A). If you need to see a specialist (including a pediatric specialist or a pediatric mental health specialist), your *PCP* will select the specialist and make the referral. Usually, your *PCP* will select and refer you to another *Provider* in the same *Provider Unit*. Because the *PCP* and the specialists already have a working relationship, this helps to provide quality and continuity of care.

If you need specialty care that is not available within your *PCP's Provider Unit* (this is an uncommon event), your *PCP* will choose a specialist in another *Provider Unit* and make the referral. When selecting a specialist for you, your *PCP* will consider any long-standing relationships that you have with any *Plan Provider*, as well as your clinical needs. (As used in this section, a long-standing relationship means that you were recently seen or treated repeatedly by that *Plan* specialist.)

If you require specialty care, which is not available through any *Plan Provider* (this is a rare event), your *PCP* may refer you, with the prior approval of an *Authorized Reviewer*, to a *Provider* not associated with the *Plan*.

Notes:

- You must obtain a specialist referral from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **before** to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Plan Providers* will not be paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For mental health and substance use disorder services, you do not need a referral from your *PCP*. However, you may need authorization from a *Tufts HP Mental Health Authorized Reviewer*. See “*Inpatient* mental health and substance use disorder services” and “*Outpatient* mental health and substance use disorder services” on pages 45 and 46 for more information.

Referral forms for specialty services

Except as provided above, your *PCP* must complete a referral every time he or she refers you to a specialist. (For *Outpatient* mental health services, this referral is completed by the *Tufts Health Plan* Mental Health Department.) Sometimes your *PCP* will ask you to give a referral form to the specialist when you go for your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve any referrals that a specialist may make to other *Providers*. Make sure that your *PCP* has made a referral before you go to any other *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Plan Provider*.

Authorized Reviewer approval

If the specialist refers you to a non-*Plan Provider*, the referral must be approved by your *PCP* and an *Authorized Reviewer*. In addition, certain *Covered Services* described in Chapter 3 must be authorized in advance by an *Authorized Reviewer*. For mental health or substance use disorder services, the referral must be approved by a *Tufts HP Mental Health Authorized Reviewer*. If you do not obtain that authorization, the *Plan* will not cover those services and supplies.

About Your *Primary Care Provider*, Continued

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Provider*.

- *Emergency Care*

Note: If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours of receiving care. (Notification from the attending physician satisfies this requirement.)

- Mammography screenings at the following intervals:

- One baseline at 35-39 years of age;
- One every year at age 40 and older; or
- As otherwise *Medically Necessary*

- *Urgent Care* outside of the *Service Area*

Note: You must contact your *PCP* for any follow-up care after receiving *Urgent Care Covered Services*.

- Care in a limited service medical clinic
- Pregnancy terminations
- Routine eye exams (covered once every 24 months)
- Chiropractic care (spinal manipulation)
- Treatment provided by an optometrist
- The following specialty care provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner:
 - Maternity care
 - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions
 - Routine annual gynecological exams, including any *Medically Necessary* follow-up obstetric or gynecological care

Note: You must obtain these services from a *Plan Provider*, except for *Emergency care*, *Urgent Care* outside of the *Service Area*, or as otherwise detailed on page 27.

Financial Arrangements between the *Plan* and *Plan Providers*

The *Plan's* goal in compensating *Providers* is to encourage preventive care and active management of illnesses. The *Plan* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for providing high quality care to our *Members*. *Tufts Health Plan* uses a variety of mutually agreed upon methods to compensate *Plan Providers*.

The *Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, the *Plan* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures, which can be both harmful and costly to *Members*.

The *Plan* oversees the provision of care through its Quality of Health Care Program. You should feel free to ask your *Provider* specific questions about how he or she is paid.

Member Identification Card

The *Plan* gives each *Member* a Member Identification card (Member ID card). Your Member ID card identifies your health care plan and your individual Member Identification Number.

When you receive your Member ID card, check it carefully. If any information is incorrect, call Member Services at 800-870-9488.

Please remember to carry your card with you at all times and bring it to your medical appointments. When you receive services, you must tell the office staff that you are a *Tufts Health Plan Member*.

IMPORTANT NOTE: If you do not identify yourself as a *Member*, and, as a result, your *PCP* and/or the *Plan* does not manage your care, then the *Plan* may not pay for the services provided. If this occurs, you may be responsible for the costs.

If you have any questions about your Member ID card, please call Member Services at 800-870-9488.

Utilization Management

This section describes the *Plan's* utilization management program.

Utilization Management The purpose of the program is to ensure that health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, the *Plan* may engage in prospective, concurrent, and/or retrospective review of health care services.

Type of Review	Timeframe for Determinations*
Prospective (Pre-Service) <ul style="list-style-type: none"> The <i>Plan</i> determines whether proposed treatment is <i>Medically Necessary</i> before it begins. 	Within 2 working days of receiving all necessary information, but no later than 15 days from receipt of the request
Concurrent <ul style="list-style-type: none"> The <i>Plan</i> monitors the course of treatment <u>as it occurs</u> and determined when it is no longer <i>Medically Necessary</i>. 	Determination is made prior to treatment being reduced or terminated. This allows you to appeal an adverse determination.
Retrospective (Post-Service) <ul style="list-style-type: none"> The <i>Plan</i> evaluates care <u>after</u> it has been provided, and to more accurately determine the appropriateness of health care services provided to <i>Members</i>. 	30 days

Note: *Members* can call the *Plan* at the following numbers to determine the status or outcome of utilization review decisions:

- Mental health or substance use disorder: 800-208-9565
- All other conditions: 800-462-0224

Utilization Management, Continued

Specialty Case Management Some *Members* with severe illnesses or injuries may receive interventions under the *Plan's* specialty case management program.

Severe illnesses and injuries include, but are not limited to, the following:

- Serious heart or lung disease
- Cancer
- Certain neurologic diseases
- AIDS or other immune system diseases
- Certain mental health conditions, including substance use disorder
- Severe traumatic injury
- High-risk pregnancy

Under this program, the *Plan* monitors *Members'* treatment and progress and encourages use of the most appropriate and cost-effective treatments.

The *Plan* may contact *Members* and their *Plan Providers* to:

- Discuss a treatment plan
- Establish short and long-term goals
- Explore potential alternative treatment settings

Members and their *Plan Providers* will be contacted if *Tufts Health Plan* identifies alternatives to the *Member's* current treatment plan that qualify as *Covered Services*, are cost effective, and are appropriate for the *Member*.

Utilization Management, Continued

Individual Case Management (ICM)

In certain circumstances, the *Plan* may authorize an individual case management (“ICM”) plan for *Members* with severe illnesses or injuries. The goal of the ICM plan is to identify and arrange for the most appropriate type, level, and setting of health care services for these *Members*.

Under the ICM plan, the *Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if the *Plan*, at its sole discretion, determines that all of the following conditions are satisfied:

- The *Member’s* condition is expected to require medical treatment for an extended time;
- The alternative services and supplies are:
 - *Medically Necessary*;
 - Provided directly to the *Member* with the condition; and
 - In place of more expensive treatment that is a *Covered Service*;
- The *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- The *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts Health Plan* authorizes an ICM plan, the *Plan* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* otherwise would have received for the *Covered Service*.

The *Plan* will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the *Plan* may modify or terminate coverage for the services or supplies provided under the ICM plan.

When You Are Ill or Injured (Non-Emergency Care) within the Service Area

This topic describes what to do when you are ill or injured (including when you need *Urgent Care*) within the *Service Area*.

Rule **Always call your *PCP*. Without authorization from your *PCP*, the *Plan* will only cover *Emergency* and *Urgent Care* services.**

Never wait until your condition becomes an *Emergency* to call.

Note: If you need medical services after hours, please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance use disorder services after hours, please call 800-208-9565 for assistance

***Inpatient* hospital services**

If you need *Inpatient* services, in most cases you will be admitted to your *PCP's Plan Hospital*.

Transfer to a *Plan Hospital*

If you are admitted to a facility other than the *Plan Hospital* in your *PCP's Provider Unit*, you will be transferred to the *Plan Hospital* in your *PCP's Provider Unit*, or another *Plan Hospital*. You will only be transferred if your *PCP* determines that transfer is appropriate.

Note: After your *PCP* has decided that a transfer is appropriate and transfer arrangements have been made, the *Plan* may elect to not cover additional *Inpatient* care provided in the facility to which you were first admitted.

Charges after discharge hour

If you choose to stay as an *Inpatient* after a *Plan Provider* has scheduled your discharge, the *Plan* will **not** pay for any costs incurred after the discharge hour.

***Outpatient* mental health/substance use disorder services**

To obtain a referral for *Outpatient* mental health or substance use disorder services, you, your *PCP*, or your *Tufts Health Plan* mental health/substance use disorder *Provider* should call 800-208-9565 to speak with the *Plan's* Mental Health/Substance Use Disorder Referral Service.

When You Need *Emergency* or *Urgent Care* (in or out of the *Service Area*)

GUIDELINES FOR RECEIVING *EMERGENCY CARE*

You do not need approval from your *PCP* before receiving *Emergency care*, whether in or out of the *Service Area*.

Go to the nearest emergency medical facility, or, if needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

If you receive *Outpatient Emergency care* at an emergency facility, you (or someone acting for you) should call your *PCP* or the *Plan* within 48 hours of receiving care. You are encouraged to contact your *PCP* so he or she can provide or arrange for any necessary follow-up care.

- If you are admitted as an *Inpatient*, you or someone acting on your behalf **must** call your *PCP* or the *Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies that requirement.) Failure to do so may result in no coverage.

GUIDELINES FOR RECEIVING *URGENT CARE*

If you are in the *Service Area*, You may seek *Urgent Care* in your *PCP's* office, in an Emergency room, in a *Limited Service Medical Clinic*, or at an *Urgent Care Center* affiliated with the *Plan*. A referral may be required if you seek *Urgent Care* from any *Plan Provider* other than your *PCP*, or from a *Limited Service Medical Clinic* or *Urgent Care Center* that are not participating with the *Plan*.

If you are outside the *Service Area*

- If you are outside of the *Service Area*, you may seek *Urgent Care* in a *Provider's* office, a *Limited Service Medical Clinic*, an *Urgent Care Center*, or the *Emergency* room.
- You or someone acting for you **must** contact your *PCP* to arrange for any necessary follow-up care.

The *Urgent Care Provider* may either bill the *Plan* directly or require you to pay for the *Urgent Care* services at the time of service. If you are required to pay, the *Plan* will pay the *Provider* up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Cost Sharing Amount*). You may receive a bill for these services. Please call Member Services or see "Bills from *Providers*" on page 88 for more information about what to do if you receive a bill for these services.

Notes:

- If you are admitted as an *Inpatient* after receiving *Urgent Care* services, you or someone acting for you **must** call your *PCP* or the *Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.) Failure to do so may result in no coverage.
- *Urgent* or *Emergency Care* services received outside of the *Service Area* are covered. However, continued services after the *Emergency* or *Urgent* condition has been treated and stabilized may not be covered if the *Plan* determines, in coordination with the *Member's* providers, that the *Member* may safely be transported back into the *Service Area*.
- If you need medical services after hours, please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance use disorder services after hours, please call 800-208-9565.

What to Do When Traveling

This section tells you what to do if you need care outside the *Service Area*. When traveling, you must know the types of services that are and are not covered by the *Plan*. (See the *Directory of Health Care Providers* for more information about the *Plan's Service Area*.)

Type of Service	Example	Coverage
Routine care	<ul style="list-style-type: none"> • General physical examinations • Gynecological or obstetrical examinations • Diagnostic tests related to general physical and gynecological examinations • Routine ongoing psychiatric treatment • Immunizations to prevent disease • Other preventive procedures 	Not covered
Elective <i>Inpatient Admissions / Day Surgery</i>	Admissions or surgery that could be safely delayed until you return to the <i>Service Area</i> .	Not covered
Care that could have been foreseen before leaving the <i>Service Area</i>	<ul style="list-style-type: none"> • Deliveries within one month of the due date, including postpartum care • Removal of stitches • Long-term conditions that require ongoing medical care. <p>Exceptions are on a case-by-case basis. Please call Member Services at 800-870-9488.</p>	Not covered
<i>Urgent Care*</i>	<ul style="list-style-type: none"> • Dislocated toe • Cut that is not bleeding heavily but needs stitches • Sudden extreme anxiety • Symptoms of a urinary tract infection 	Covered
<i>Emergency care*</i>	<ul style="list-style-type: none"> • Broken leg • Chest pains • Difficulty breathing • Heavy bleeding • Loss of consciousness • Vomiting blood • Severe pain 	Covered

***Note:** If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours of receiving care. Notification from the attending physician satisfies this requirement.

Information Resources for *Members*

Obtaining information about the *Plan*

The following information about the *Plan* is available from the Massachusetts Health Policy Commission's Office of Patient Protection:

- A list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by the *Plan*.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with the *Plan* during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those physicians.
- The percentage of *Premium* revenue spent by the *Plan* for health care services provided to *Members* for the most recent year for which information is available.
- A report that details the following information from the previous calendar year:
 - Total numbers of filed grievances, grievances denied internally, and grievances withdrawn before resolution; and
 - Total number of external appeals pursued after exhausting the internal grievance process, as well as the resolution of all those external appeals.

How to obtain this information

You can obtain this information by contacting the Massachusetts Healthy Policy Commission's Office of Patient Protection, below:

Health Policy Commission, Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116
800-436-7757
Fax: 617-624-5046
mass.gov/hpc/opp
HPC-OPP@state.ma.us

Chapter 2

Eligibility

This chapter tells you who is eligible, how to enroll, and when coverage starts.

Eligibility rule You are eligible as a *Member* only if you meet all of the following criteria, subject to federal law:

- Maintain primary residence in the *Service Area* and live in the *Service Area* for at least 9 months in each period of 12 months (12-month period begins with the first month you are not living in the *Service Area*)
- Are enrolled in Medicare Parts A and B

Note: If you have a *Dependent* who is not covered by Medicare, he or she may enroll in one of *Tufts Health Plan's* non-Medicare plans.

- Meet the eligibility rules and regulations of the *Group Insurance Commission* and the *Plan*

Proof of eligibility The *Plan* may ask you for proof of your eligibility or continuing eligibility. If asked, you must provide the *Plan* proof of residence and Medicare Parts A and B enrollment, as well as any other necessary information.

When to enroll You may enroll yourself for this coverage only during the annual *Open Enrollment Period*, or within 31 days of the date you are first eligible for coverage.

Effective Date of coverage If the *Plan* accepts your application and receives the *Premium*, coverage starts on the following dates:

- **For persons applying during an annual enrollment period**, coverage begins each year on July 1.
- **For new retirees/Medicare enrollees and surviving spouses** (upon application), you will be notified by the *Group Insurance Commission* of the date your coverage begins.

If you are an *Inpatient* on your *Effective Date*, your coverage starts on the later of the *Effective Date*, or the date the *Plan* is notified and given the chance to manage your care.

Note: Italicized words are defined in Appendix A.

Chapter 3

Covered Services

Overview

This chapter describes the health care services and supplies covered under the Tufts Medicare Complement Plan. It contains the following topics:

Topic	See Page
<i>Covered Services</i>	27
Part A Medicare Benefits	28
Part B Medicare Benefits	34
Mental Health and Substance Use Disorder Services (Parts A and B)	45
Other <i>Covered Services</i> (outside of Parts A and B)	47
<i>Tufts Health Plan</i> Member Discounts	60
Prescription Drug Benefit	64
Exclusions from Benefits	72

Note: Italicized words are defined in Appendix A.

Covered Services

When health care services are Covered Services

Health care services and supplies are *Covered Services* only if they are:

- Listed as *Covered Services* in this chapter, or covered under Medicare Parts A and B. (These services are covered under this TMC Plan, even if they are not specifically listed in this Evidence of Coverage.);
- *Medically Necessary*, as determined by the *Plan* and Medicare Parts A and B;
- Consistent with applicable state and federal law;
- Provided to treat an injury, illness or pregnancy, or are preventive care services;
- Provided or authorized in advance by your *PCP*, except for *Emergency* or *Urgent Care*;
- Consistent with *Tufts Health Plan's* Clinical Coverage Guidelines (available at tuftshealthplan.com or by calling Member Services) in effect at the time the services or supplies are provided; and
- Approved by an *Authorized Reviewer*, if required.

IMPORTANT NOTES:

PCP Authorization: When care is not provided or authorized by your *PCP*, the *Plan* does not pay for any services or supplies other than *Medically Necessary Emergency* and *Urgent Care* services (as described on pages 38 and 47). You will be responsible for paying any amount not covered by Medicare.

If your care is provided or authorized by your *PCP*, the *Plan* will pay the:

- *Deductibles* and *Coinsurance* for Medicare-eligible services (under Medicare Parts A and B); and
- Applicable benefit amount for all other *Covered Services*.

Please see the *Covered Services* tables in Chapter 3 to determine which *Covered Services* have a *Copayment*.

Authorized Reviewer approval: Certain *Covered Services* described in the table below must be authorized in advance by an *Authorized Reviewer*. If you do not obtain authorization, the *Plan* will not cover those services and supplies.

Covered Services, Continued

Covered Services (Part A) The following section describes the *Covered Services* available to you under Medicare Part A of Original Medicare and the Tufts Medicare Complement Plan.

Part A Benefits			
BENEFIT	MEDICARE PAYS...	WHEN CARE AUTHORIZED BY YOUR PCP	
		The Plan Pays...	You Pay...
<i>Inpatient services</i>	<u>Days 1-60 in <i>Benefit Period</i></u> : All <i>Covered Services</i> , except the Medicare Part A <i>Deductible</i>	The Medicare Part A <i>Deductible</i>	Nothing
	<u>Days 61-90 in <i>Benefit Period</i></u> : All covered costs, except the Medicare hospital coinsurance	The Medicare hospital coinsurance	Nothing
	<u><i>Reserve Days</i></u> :* All <i>Covered Services</i> , except the Medicare <i>Reserve Day</i> coinsurance (*Under Medicare, you have 60 extra lifetime Medicare <i>Reserve Days</i> for <i>Inpatient services</i>)	The Medicare <i>Reserve Day</i> coinsurance, and for all <i>Covered Services</i> after <i>Reserve Days</i> are exhausted	Nothing for <i>Reserve Days</i> , or for <i>Covered Services</i> after <i>Reserve Days</i> are exhausted

Covered inpatient care services at a Medicare-certified general hospital include:

- Semiprivate room (private room if *Medically Necessary*)
- Regular nursing services
- *Inpatient* physician services
- Surgery (including mastectomy-related care, below)
- Use of operating/recovery rooms
- Meals, including special diets
- Drugs and medications furnished by the hospital during your stay;
- Laboratory tests, X-rays, and other radiological services
- Medical supplies, such as casts, surgical dressings, and splints
- Cost of special care units, including intensive care and coronary care units
- Rehabilitation services, such as physical therapy, occupational therapy, speech pathology services, nuclear medicine, and kidney dialysis

- Maternity care services (no *PCP* referral required)
- Psychiatric and/or psychologist services in a general hospital
- Substance use disorder detoxification and rehabilitation services
- The following services in connection with a mastectomy:
 - (1) Reconstruction of the breast affected by the mastectomy
 - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - (3) Prostheses (covered as described under "*Durable Medical Equipment*") and treatment of physical complications of all stages of mastectomy (including lymphedema)
 - (4) Removal of breast implants, if the implants were placed post-mastectomy (**Note:** Coverage will also be provided for removal of breast implants if there is documented auto-immune disease or a documented rupture of a silicone implant.)
- All other *Medically Necessary* services and supplies

Note: Neither the *Plan* nor Medicare covers private duty nursing services.

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
<i>Inpatient</i> blood services	All <i>Covered Services</i> , except for the annual Medicare blood <i>deductible</i>	Your annual Medicare blood deductible	Nothing	The annual Medicare blood deductible

The *Plan* covers *Inpatient* blood services when those services are provided as part of a covered *Inpatient* stay in a hospital or *Skilled* Nursing Facility. *Covered Services* include whole blood, packed red blood cells, blood components, and the cost of blood processing and administration.

Note: Under Medicare, you have an annual deductible for the first 3 pints of unreplaced blood in a calendar year.

Covered Services, Continued

Part A Benefits (continued)				
Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Skilled Nursing Facility (SNF) care	<u>Days 1-20 in a Benefit Period:</u> All Covered Services	Nothing	Nothing	Nothing
	<u>Days 21-100 in a Benefit Period:</u> All Covered Services, except for the Medicare SNF <i>Coinsurance</i>	The Medicare SNF <i>Coinsurance</i>	Nothing	The Medicare SNF <i>Coinsurance</i> for each day
	<u>Days 101+ in a Benefit Period:</u> Nothing	Nothing	All charges after a 100-day SNF stay	All charges after a 100-day SNF stay

Covered *Skilled* nursing and rehabilitation services include the following, when performed by or provided under the supervision of licensed nursing personnel:

- Semi-private room
- Nursing services
- Meals, including special diets;
- Physical, occupational, and speech therapy
- Drugs and medications furnished by the *skilled* nursing facility during your stay
- Medical supplies, such as casts, surgical dressings, and splints
- Diagnostic services, such as x-rays and laboratory services

Note: Neither Medicare nor the *Plan* covers custodial care, including custodial care provided in a SNF.

Covered Services, Continued

Part A Benefits (continued)				
Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Home Health Care Services	<u>Nutritional counseling and physician home visits,</u> Nothing	<i>All Medically Necessary</i> charges	Nothing	All charges
	<u>Durable Medical Equipment:</u> 80% of the Medicare-approved amount	20% of the Medicare-approved amount	Nothing	All charges
	<u>All other Covered Services:</u> All Charges	Nothing	Nothing	Nothing

The *Plan* covers the following services provided by a home health agency to a homebound *Member* at home:

- Part-time or intermittent *Skilled* nursing care
- Nutritional counseling
- Physical therapy
- Speech therapy

If you need intermittent *Skilled* nursing care, physical therapy, or speech therapy, Medicare may also cover:

- Occupational therapy
- Part-time or intermittent services from a home health aide
- Medical social services
- Medical supplies and *Durable Medical Equipment* provided by a Home Health Agency

Note: Neither the *Plan* nor Medicare covers *Custodial Care*.

Covered Services, Continued

Part A Benefits (continued)				
Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
<i>Inpatient</i> services at a chronic care or rehabilitation facility	<u>Days 1-60 in a <i>Benefit Period</i>:</u> All <i>Covered Services</i> , except Part A <i>Deductible</i>	The Medicare Part A <i>Deductible</i>	Nothing	The Medicare Part A <i>Deductible</i>
	<u>Days 61-90 in a <i>Benefit Period</i>:</u> All <i>Covered Services</i> , except hospital <i>Coinsurance</i>	The Medicare hospital coinsurance	Nothing	The Medicare hospital coinsurance
	<u><i>Reserve Days</i>:</u> All <i>Covered Services</i> , except Medicare <i>Reserve Day Coinsurance</i> for 60 extra lifetime <i>Reserve Days</i>	The Medicare <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i>	Nothing	The Medicare <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i>
	<u><i>Additional Days</i>:</u> Nothing	All charges for the remainder of 100 days (whether covered or excluded by Medicare) in a calendar year	Nothing for days up to 100 per calendar year All charges for days over 100 per calendar year not covered by the <i>Plan</i>	All charges for days up to 100 per calendar year All charges for days over 100 per calendar year not covered by the <i>Plan</i>

The *Plan* provides coverage for acute *Inpatient* rehabilitation services provided in an *Inpatient* rehabilitation facility.

Covered Services, Continued

Part A Benefits (continued)				
Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Hospice care	<u>Medicare-approved <i>Inpatient</i> respite care:</u> All <i>Covered Services</i> , except Medicare Part A <i>Coinsurance</i>	The Medicare Part A <i>Coinsurance</i>	Nothing	The Medicare Part A <i>Coinsurance</i>
	<u>Covered prescription drugs:</u> All charges except the <i>Copayment</i>	The Medicare Part A <i>Copayment</i>	Nothing	The Medicare Part A <i>Copayment</i>
	<u>All other <i>Covered Services</i>:</u> All <i>Covered Services</i>	Nothing	Nothing	Nothing

The *Plan* covers the following hospice care services for terminally ill *Members* with a life expectancy of six (6) months or less:

- Home care provided by a public agency or private organization focused on providing comfort and relief from pain. Coverage includes physician services; nursing care; medical appliances and supplies; and physical therapy, occupational therapy and speech therapy.
- Services not ordinarily covered by Medicare, including homemaker services, counseling, and certain prescription drugs for pain or symptom relief. (Prescription drug *Copayment* may apply.)
- Up to five (5) consecutive days of *Inpatient* respite care to temporarily relieve the family or primary care person from caregiving duties. (*Coinsurance* may apply).

Covered Services, Continued

The following two sections describe the *Covered Services* available to you under Medicare Part B and the Tufts Medicare Complement Plan.

Note: Certain Part B preventive care services indicate that Medicare pays 100% of the Medicare-approved amount; however, Medicare may charge you the Part B *Deductible* or *Coinsurance* when these services are provided with an office visit.

Part B Benefits: Preventative Care Services

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
		The Plan Pays...	You Pay...	You Pay...
Annual pap smear, including pelvic exam	All <i>Covered Services</i> (clinical laboratory charges) for exams covered by Medicare	All <i>Covered Services</i> for exams <u>not</u> covered by Medicare	Nothing	All charges after the Medicare payment

Medicare covers the full cost of one pelvic exam every two years. Women may also receive coverage under Medicare for an annual exam if they are at high risk for cervical or vaginal cancer, or of childbearing age and have had an abnormal pap smear in the past 3 years.

Note: The *Plan* will cover the cost of an annual pap smear in years that Medicare does not cover this exam.

Colorectal cancer screening exams	<u>Fecal-occult blood tests, sigmoidoscopy, and colonoscopy:</u> 100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
	<u>Barium enema:</u> 80% of the Medicare-approved amount	20% of the Medicare-approved amount, minus a \$10 <i>Copayment</i> per office visit (if applicable)	\$10 <i>Copayment</i> per office visit (if applicable)	All charges after the Medicare payment

Covered colorectal cancer screening services include:

- Fecal-occult blood test once every year for persons age 50 and over
- Flexible sigmoidoscopy once every four years for persons age 50 and over
- Colonoscopy once every two years for persons at high risk of colorectal cancer
- Colonoscopy once every 120 months (or 48 months after a previous flexible sigmoidoscopy) for persons not at high risk for colorectal cancer.
- Barium enema, as a physician-ordered substitute for sigmoidoscopy or colonoscopy

Covered Services, Continued

Part B Benefits: Preventative Care Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Mammogram	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment

The *Plan* provides coverage for a baseline mammogram for women between 35 and 40, and annual mammography screenings for women age 40 and over.

Prostate cancer screening	<u>Digital rectal exam:</u> 80% of the Medicare-approved amount, except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% of the Medicare-approved amount (plus Medicare hospital <i>Copayment</i> , if applicable)	Nothing	All charges after the Medicare payment
	<u>PSA test:</u> 100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment

Covered prostate cancer screening services for men age 50 and above include digital rectal exams and PSA tests.

Note: Medicare charges a hospital *Copayment* for digital rectal exams performed in a hospital outpatient department.

Vaccinations	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
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Covered vaccinations include those for the flu (once per year), pneumonia, and Hepatitis B. Hepatitis B vaccinations are only covered for *Members* at medium- to high-risk for Hepatitis.

Covered Services, Continued

Part B Benefits: Preventative Care Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
		The Plan Pays...	You Pay...	The Plan Pays...
Mammogram	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment

The *Plan* provides coverage for a baseline mammogram for women between 35 and 40, and annual mammography screenings for women age 40 and over.

Prostate cancer screening	<u>Digital rectal exam:</u> 80% of the Medicare-approved amount, except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% of the Medicare-approved amount (plus Medicare hospital <i>Copayment</i> , if applicable)	Nothing	All charges after the Medicare payment
	<u>PSA test:</u> 100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment

Covered prostate cancer screening services for men ages 50 and above include digital rectal exams and PSA tests.

Note: Medicare charges a hospital *Copayment* for digital rectal exams performed in a hospital outpatient department.

Vaccinations	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
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Covered vaccinations include those for the flu (once per year), pneumonia, and Hepatitis B. Hepatitis B vaccinations are only covered for *Members* at medium- to high-risk for Hepatitis.

Part B Benefits: Other *Outpatient* Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i> *
		The <i>Plan</i> Pays...	You Pay...	The <i>Plan</i> Pays...
Bone mass measurement	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment

The *Plan* provides coverage once every 24 months for *Members* at risk of losing bone mass.

Diabetes self-management training	80% of the Medicare-approved amount, except for the annual Part B <i>Deductible</i>	The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount	Nothing	All charges after the Medicare payment
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Diabetes self-management training includes outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes.

Note: Services must be provided by a *Tufts HP Provider* who is a certified diabetes health care provider.

Medicare-approved smoking cessation program	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
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Medical nutrition therapy	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
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Physical examinations	100% of the Medicare-approved amount	Nothing	Nothing	All charges after the Medicare payment
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Covered Services include a one-time physical exam within 12 months after Part B coverage begins, and an annual wellness exam each year thereafter.

Part B Benefits: Other *Outpatient* Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i> *
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Emergency room care	80% of Medicare-approved <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus a \$50 <i>Copayment</i> per visit	\$50 <i>Copayment</i> per visit	Not applicable

The *Plan* covers *Medically Necessary Emergency* services obtained in an emergency room in the United States. **No *PCP* referral is required for *Emergency* services.** See “*Covered Services* Outside of Medicare Parts A and B” below for information about obtaining Emergency room care outside of the United States.

Note: The Emergency Room *Copayment* is waived if you are admitted as an *Inpatient*. It may apply if you register in an Emergency room but leave without receiving care. The *Copayment* does not apply to *Observation* services.

<i>Outpatient</i> services	80% of Medicare-approved <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus a \$10 <i>Copayment</i> per visit	\$10 <i>Copayment</i> per visit	All charges after the Medicare payment
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Covered *Outpatient* services include:

- Office visits
- Consultation by specialists, including obstetrical and gynecological services
- Allergy testing and treatment;
- *Outpatient* physical, occupational, and speech therapy (for diagnosis and treatment of speech, hearing, and language disorders)
- Medical services and surgery;
- Immunizations
- Diagnostic imaging services, including general imaging (such as x-rays, and ultrasounds), MRI/MRA, CT/CTA, PET, and nuclear medicine
- Inhalation and other home health therapies
- Radiation therapy
- Manipulation of the spine to correct a dislocation that can be shown by an x-ray

Part B Benefits: Other *Outpatient Services* (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i> *
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Diagnostic laboratory services	All <i>Covered Services</i>	Nothing	Nothing	All charges after the Medicare payment

Diagnostic laboratory services include, but are not limited to, glycosolated hemoglobin (A1c) and urinary protein/microalbumin and lipid profiles.

Podiatric services	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus a \$10 <i>Copayment</i> per visit	\$10 <i>Copayment</i> per visit	All charges after the Medicare payment
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Services must be Medicare-approved and provided by a doctor of podiatry or surgical chiropody.

Note: Routine foot care is not covered.

Dental services	<u>Outpatient care:</u> 80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus applicable <i>Copayment</i>	\$10 <i>Copayment</i> per office visit -OR- \$50 <i>Copayment</i> per Emergency Room visit	All charges after the Medicare payment
	<u>Inpatient/ambulatory services:</u> 80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i>	Nothing	All charges after the Medicare payment

The *Plan* covers a very limited number of *Outpatient* dental services. *Covered Services* include (1) Trauma care, reduction of swelling, and pain relief for damage to sound and natural teeth; and (2) Reduction of dislocations or fractures of the jaw.

The *Plan* covers *Inpatient* or ambulatory surgical services for non-dental medical conditions that require you to be in a hospital when you receive dental care.

Note: Routine dental care is not covered.

Covered Services, Continued

Part B Benefits: Other Outpatient Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
		The Plan Pays...	You Pay...	You Pay...
Physical therapy, occupational therapy, and speech pathology services	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus a \$10 <i>Copayment</i> per visit	\$10 <i>Copayment</i> per visit	All charges after the Medicare payment

Services must be provided in a clinic, hospital, rehabilitation facility, or SNF; or by a home health agency or independent practicing therapist.

Outpatient blood services	80% of <i>Covered Services</i> , except for the annual Medicare Blood <i>Deductible</i> and the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> , minus a \$10 <i>Copayment</i> per visit	\$10 <i>Copayment</i> per visit	All charges after the Medicare payments
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Covered *Outpatient* blood services include whole blood, packed red blood cells, blood components, and the cost of blood processing and administration.

Note: Under Medicare, you have an annual deductible for the first 3 pints of unreplaced blood in a calendar year.

Covered Services, Continued

Part B Benefits: Other Outpatient Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i> *
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Ambulance services	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i>	Nothing	Not applicable

Ambulance services are covered for transportation between any of the following:

- Your home and a hospital
- Your home and a *Skilled* Nursing Facility (SNF)
- A hospital and a SNF

Services are covered only if the ambulance and personnel meet Medicare requirements, and if **transportation in any other vehicle could endanger your health.**

Note: If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff but refuse to be transported to the hospital or other medical facility, you may be responsible for the costs of this treatment.

Covered Services, Continued

Part B Benefits: Other Outpatient Services (continued)

Benefit	Medicare Pays... CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i> *
		The <i>Plan</i> Pays...	You Pay...	You Pay...
<i>Durable Medical Equipment (DME)</i>	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i> .	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i> .	Nothing	All charges after the Medicare payment.

Durable Medical Equipment includes coverage for devices or instruments of a durable nature (including breast prostheses and surgical brassieres after a mastectomy) that are:

- Reasonable and necessary to sustain a minimum threshold of independent daily living;
- Made primarily to serve a medical purpose;
- Not useful in the absence of illness or injury;
- Able to withstand repeated use; and
- Intended for use in the home.

To be eligible for coverage, the DME must be the most appropriate available supply or service for the *Member*, considering the potential benefits and harms to that individual.

Equipment that *Tufts Health Plan* determines to be non-medical in nature and used primarily for non-medical purposes will not be considered *Durable Medical Equipment* and will not be covered under this benefit. This is true even if that equipment may have some limited medical use.

Note: You must use a vendor that has an agreement with *Tufts Health Plan* to provide such supplies.

Covered Services, Continued

Part B Benefits: Other Outpatient Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
		The Plan Pays...	You Pay...	You Pay...
Medical supplies	80% of <i>Covered Services</i> , except annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i>	Nothing	All charges after the Medicare payment

Examples of *Covered Services* include dressings, splints, and casts.

Diabetes monitoring equipment	80% of Medicare-approved <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> and 20% <i>Coinsurance</i>	Nothing	All charges after the Medicare payment
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The *Plan* covers the following services and supplies for members with diabetes:

- Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind
- Visual magnifying aids
- Therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disorder
- Blood glucose monitoring strips
- Lancets
- Diabetes self-management training

Note: *Tufts Health Plan* also pays for the following *Covered Services*, to the extent they are not otherwise covered by Medicare:

- Urine and ketone monitoring strips. See the Prescription Drug Benefit on page 68 for more information.
- Diabetes self-management. See “Diabetes self-management training and educational services” on page 54 for more information.

Part B Benefits: Other *Outpatient* Services (continued)

Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
		The <i>Plan</i> Pays...	You Pay...	You Pay...
Comprehensive <i>Outpatient</i> Rehabilitation Facility (CORF)	80% of <i>Covered Services</i> , except annual Medicare Part B <i>Deductible</i> (subject to CORF calendar year maximum benefits)	The annual Medicare Part B deductible, and 20% <i>Coinsurance</i> , subject to the CORF calendar year maximum benefits	All charges after the Medicare calendar year CORF maximum benefits	All charges after the Medicare payment

The *Plan* provides coverage for *Outpatient* rehabilitation services at a Comprehensive *Outpatient* Rehabilitation Facility (CORF).

Note: Under Medicare, you have CORF calendar year maximum benefits in 2016 of:

- \$1,960 for physical therapy; and
- \$1,960 for occupational therapy.

Covered Services, Continued

Mental health and substance use disorder services

The following table describes the mental health and substance use disorder services available to you under Medicare Parts A and B of Original Medicare and the Tufts Medicare Complement Plan.

Mental Health and Substance Use Disorder Benefits (Parts A and B)				
Benefit	Medicare Pays... CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
		The Plan Pays...	You Pay...	You Pay...
<i>Inpatient</i> mental health and substance use disorder services (Part A)	<u>In a general hospital:</u> All <i>Covered Services</i> , except for the annual Medicare Part A <i>Deductible</i>	For Days 1-60 in a <i>Benefit Period</i>: The Medicare Part A <i>Deductible</i> and <i>Coinsurance</i>	Nothing	All charges after the Medicare payment
	For Days 61-90 in a <i>Benefit Period</i>: The Medicare Part A <i>Coinsurance</i>			
	<u>Days 1 - 190 (lifetime) in psychiatric hospital:</u> All <i>Covered Services</i> , except for the annual Medicare Part A <i>Deductible</i>	The Medicare Part A <i>Deductible</i> and <i>Coinsurance</i>	Nothing	All charges after the Medicare payment
<u>Additional Days in psychiatric hospital:</u> Nothing	All charges	All charges	All charges	

Covered Services, Continued

Mental Health and Substance Use Disorder Services (Parts A and B) (continued)				
Benefit	Medicare Pays...	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY PCP
		The Plan Pays...	You Pay...	You Pay...
Intermediate mental health and substance use disorder services (Part B)	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i> .	The annual Medicare Part B <i>Deductible</i> , and 20% <i>Coinsurance</i>	Nothing	All charges after the Medicare payment

Tufts Health Plan pays for the following *Covered Services* for intermediate mental health and substance use (alcohol and drug) disorder services, to the extent that these services are not otherwise covered by Medicare. Intermediate mental health and substance use disorder services are more intensive than traditional *Outpatient* mental health and substance use disorder services but less intensive than 24-hour hospitalization. Examples include:

- Intensive *Outpatient* Programs (IOP)
- Crisis stabilization
- Acute residential treatment (longer term residential treatment is not covered)
- Day treatment/partial hospital programs
- Level III community-based detoxification

Note: Intermediate mental health and substance use disorder services may require prior notification. If you have any questions, please contact the *Plan's* Mental Health/Substance Use Disorder Referral Service at call 800-208-9565.

<i>Outpatient</i> mental health and substance use disorder services (Part B)	80% of <i>Covered Services</i> , except for the annual Medicare Part B <i>Deductible</i>	The annual Medicare Part B <i>Deductible</i> , and 20% <i>Coinsurance</i> , minus a \$10 Copayment per visit	\$10 <i>Copayment</i> per visit	All charges after the Medicare payment
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The *Plan* covers *Outpatient* services for the diagnosis and treatment of a mental health condition or substance use disorder.

Note: Psychopharmacological (prescription drug) services and neuropsychological services are covered as “*Outpatient Services*” under Part B.

Covered Services, Continued

The following section describes services that the *Plan* covers but Medicare may not. Massachusetts law requires the *Plan* to cover some of these services.

Covered Services outside of Medicare Parts A and B

Benefit	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
	The <i>Plan</i> Pays...	You Pay...	You Pay...
Routine eye exam	All <i>Covered Services</i>	Nothing	Not applicable

The *Plan* covers one routine eye exam every 24 months. You must receive routine eye examinations from an EyeMed Vision Care network *Provider* to obtain coverage. **No *PCP* referral is required.** Please visit tuftshealthplan.com or contact Member Services for more information.

Note: To be covered for services to treat a medical condition of the eye, you must obtain a referral from your *PCP*.

Hearing exams and screenings	All <i>Covered Services</i>	Nothing	Not applicable
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Hormone replacement therapy services	All <i>Covered Services</i>	Nothing	Not applicable
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Emergency room care outside of the United States	All <i>Covered Services</i>	Nothing	Not applicable
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The *Plan* covers *Medically Necessary Emergency* services obtained in a hospital *Emergency* room outside of the United States. **No *PCP* referral is required.** See “Part B Benefits” above for information about obtaining *Emergency* room care within the United States.

Note: The *Emergency* room *Copayment* is waived if you are admitted as an *Inpatient*. It may apply if you register in an *Emergency* room but leave without receiving care. The *Copayment* does not apply to *Observation* services.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
	The Plan Pays...	You Pay...	You Pay...
Outpatient contraceptive services	All Covered Services	Nothing	All charges

Coverage is provided for *Outpatient* contraceptive services, including consultations, examinations, procedures and medical services related to the use of all contraceptive methods approved by the United States Food and Drug Administration (FDA). Family planning services and procedures include:

- Medical examinations
- Consultations
- Birth control counseling
- Genetic counseling
- Sterilization
- Pregnancy termination
- Contraceptives, including cervical caps, Intrauterine Devices (IUDs), implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent, and any other *Medically Necessary* contraceptive device that has been approved by the United States Food and Drug Administration

Note: *Tufts Health Plan* covers certain contraceptives, such as oral contraceptives and diaphragms, under your Prescription Drug Benefit. For more information, see that benefit on page 65.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
	The <i>Plan</i> Pays...	You Pay...	You Pay...
Cardiac rehabilitation	All <i>Covered Services</i>	Nothing	All charges

The *Plan* covers services for the *Outpatient* treatment of documented cardiovascular disease that: (1) Meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) Are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

- *Outpatient* convalescent phase of the rehabilitation program following hospital discharge
- *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise

Note: The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Coronary Artery Disease Program	90% of charges for all <i>Covered Services</i>	10% <i>Coinsurance</i>	All charges
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A Coronary Artery Disease secondary prevention program assists *Members* with documented Coronary Artery Disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when *Medically Necessary*, at designated programs to *Members* who meet the clinical criteria established for this program.

For more information about this program, *Members* should call Member Services at 800-870-9488.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
	The Plan Pays...	You Pay...	You Pay...
Hemodialysis	<u>Outpatient Services for Items (1) and (2) below:</u> All Covered Services	Nothing	All charges
	<u>Covered Home Services for Items (1) and (2):</u> All Covered Services	Nothing	All charges
	<u>Covered Home Services for Item (3):</u> The first \$300 of Covered Services; and 50% of the Reasonable Charge for additional Covered Services	Nothing for the first \$300 of Covered Services; and 50% of the Reasonable Charge for additional Covered Services	All charges

The *Plan* covers the following *Outpatient* hemodialysis services and supplies, when *Medically Necessary*:

- (1) Services, equipment, and supplies necessary to perform dialysis
- (2) Routine dialysis monitoring, lab, and other tests
- (3) Installation and maintenance of a dialyzer or deionizer

Note: *Outpatient Services* must be provided at a *Plan Provider* or other *Plan*-designated facility. Services provided at the *Member's* home must be provided by a *Plan*-designated vendor.

Bone marrow transplants for breast cancer	All Covered Services	Nothing	All charges
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The *Plan* covers bone marrow transplants for *Members* diagnosed with metastatic breast cancer who meet the criteria established by the Massachusetts Department of Public Health.

Note: This benefit must be approved by an *Authorized Reviewer*.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
	The <i>Plan Pays</i>...	You Pay...	You Pay...
Human Leukocyte Antigen Testing	All Covered Services	Nothing	All charges

Human leukocyte antigen testing or histocompatibility locus antigen testing is covered when necessary to establish a *Member's* suitability to be a bone marrow transplantation donor.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP
	The Plan Pays...	You Pay...	You Pay...
Medical nutrition therapy	<u>Special Medical Formulas</u> and <u>Nonprescription enteral formulas:</u> All <i>Covered Services</i>	Nothing	All charges
	<u>Low Protein Foods:</u> All <i>Covered Services</i> , up to \$5,000 per plan year	All <i>Covered Services</i> , after the \$5,000 maximum benefit has been reached	All charges

This benefit includes special medical formulas, nonprescription enteral formulas, and low protein foods when prescribed by a physician for to treat the below conditions:

- **Special Medical Formulas** for:
 - Phenylketonuria (including formulas to protect the fetus of a woman with PKU, when *Medically Necessary*)
 - Tyrosinemia
 - Homocystinuria
 - Maple syrup urine disease
 - Propionic academia
 - Methylmaloric academia
- **Low Protein Foods**, when given to treat inherited diseases of amino acids and organic acids
- **Nonprescription enteral formulas** for home treatment of:
 - Malabsorption caused by Crohn's disease
 - Ulcerative colitis
 - Gastroesophageal reflux
 - Gastrointestinal motility
 - Chronic intestinal pseudo-obstruction
 - Inherited diseases of amino acids and organic acids.
 - *Medically Necessary* formulas, including infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure

Note: This benefit may require approval from an *Authorized Reviewer*.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
	The Plan Pays...	You Pay...	You Pay...
Hearing Aids	<u>Members 21 and under:</u> Covered in full Limit of \$2,000 per ear every 36 months	Any additional cost above the limit	All charges
	<u>Members 22 and over:</u> First \$500 is covered in full; then, 80% of the next \$1,500 Limit of \$1,700 in a 24-month period	20% <i>Coinsurance</i> (for charges from \$500-\$2,000), plus any additional cost above the limit	All charges

Hearing aids (including fittings) are covered when *Medically Necessary* and prescribed by a physician.

Note: The *Plan* will cover up to \$2,000 per ear every 36 months for *Members* age 21 and under, and a total of up to \$1,700 every 24 months for *Member* age 22 or older.

Medical Supplies	All Covered Services	Nothing	All charges
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The *Plan* covers the cost of certain types of medical supplies from an authorized vendor, including:

- Ostomy
- Tracheostomy
- Catheter
- Oxygen supplies
- Insulin pumps and related supplies

Note: These supplies must be obtained from a vendor that has an agreement with *Tufts Health Plan* to provide such supplies.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)

Benefit	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
	The <i>Plan Pays</i> ...	You Pay...	You Pay...
Diabetes self-management and educational training services	All <i>Covered Services</i> , minus a \$10 <i>Copayment</i>	\$10 <i>Copayment</i>	All charges

The *Plan* offers coverage for *Outpatient* self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided by a *Plan Provider* who is a certified diabetes health care provider

Note: These services are also covered under your Medicare Part B benefits. For more information, see “Diabetes self-management training” under the “Part B Benefits” section earlier in this chapter.

Scalp hair prostheses or wigs	All <i>Covered Services</i> , up to \$350 per plan year	For all services after the \$350 limit has been reached	All charges
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Covered services include scalp hair prostheses or wigs worn for hair loss resulting from the treatment of any form of cancer or leukemia.

Patient care services provided as part of a qualified clinical trial for the treatment of cancer	<u><i>Inpatient care:</i></u> All <i>Covered Services</i> <u><i>Outpatient care:</i></u> All <i>Covered Services</i> , minus a \$10 <i>Copayment</i>	<u><i>Inpatient care:</i></u> Nothing <u><i>Outpatient care:</i></u> \$10 <i>Copayment</i>	All charges
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As required by Massachusetts law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Inpatient* or *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR PCP		CARE NOT AUTHORIZED BY YOUR PCP*
	The Plan Pays...	You Pay...	You Pay...
Patient care services provided as part of a qualified clinical trial for the treatment of cancer	<u>Inpatient care:</u> All Covered Services <u>Outpatient care:</u> All Covered Services, minus a \$10 Copayment	<u>Inpatient care:</u> Nothing <u>Outpatient care:</u> \$10 Copayment	All charges

As required by Massachusetts law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Inpatient* or *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Non- Medicare-approved smoking cessation counseling services	All Covered Services	Nothing	All charges
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Covered smoking cessation services (in addition to those approved by Medicare, described earlier in this chapter) include the QuitWorks program, as well as services from physicians, nurse practitioners, physician assistants, nurse midwives, and *Tobacco Cessation Counselors*.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR TUFTS HP PCP		CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP
	The Plan Pays...	You Pay...	You Pay...
Autism spectrum disorders – diagnosis and treatment	<u>Psychiatric and psychological care; therapeutic care; and habilitative or rehabilitative care from a Paraprofessional or Board-Certified Behavior Analyst (BCBA):</u> All Covered Services, minus a \$10 Copayment	<u>Psychiatric and psychological care; therapeutic care; and habilitative or rehabilitative care from a Paraprofessional or Board-Certified Behavior Analyst (BCBA):</u> \$10 Copayment	All charges
	<u>Prescription medications:</u> See the “Coverage for Other Prescription Drugs” section below	<u>Prescription medications:</u> See the “Coverage for Other Prescription Drugs” section below	All charges

Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive *Developmental* disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, and include autistic disorder, Asperger’s disorder, and pervasive *Developmental* disorders not otherwise specified.

Covered Services include:

- Habilitative or rehabilitative care: professional, counseling and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavior analysis (ABA) supervised by a *Board-Certified Behavior Analyst*. **For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.**
- Prescription medications (see the “Coverage for Other Prescription Drugs” section below)
- Psychiatric and psychological care (see the “Mental Health and Substance Use Disorder Services” benefit earlier in this chapter)
- Therapeutic care, including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers (see the “Physical therapy, occupational therapy, and speech pathology services “ benefit earlier in this chapter)

For more information about these programs, call the *Tufts Health Plan* Mental Health/Substance Use Disorder Department at 800-208-9565.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR TUFTS HP PCP		CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP
	The Plan Pays...	You Pay...	You Pay...
Cleft lip and cleft palate treatment and services for children	<u>Medical or facial surgery, including Inpatient services and Day Surgery:</u> All Covered Services	Nothing	All charges
	<u>Nutrition services:</u> All Covered Services, minus a \$10 Copayment	\$10 Copayment	All charges
	<u>Oral surgery:</u> • <u>Office Visit:</u> All Covered Services, minus a \$10 Copayment • <u>Emergency Room:</u> All Covered Services, minus a \$50 Copayment • <u>Inpatient services and Day Surgery:</u> All Covered Services	• <u>Office Visit:</u> \$10 Copayment • <u>Emergency Room:</u> \$50 Copayment • <u>Inpatient services and Day Surgery:</u> Nothing	• <u>Office Visit:</u> All charges • <u>Emergency Room:</u> \$50 Copayment • <u>Inpatient services and Day Surgery:</u> All charges
	<u>Dental surgery or orthodontic treatment and management:</u> All Covered Services	Nothing	All charges
	<u>Preventive and restorative dentistry:</u> All Covered Services	Nothing	All charges
	<u>Speech therapy and audiology services:</u> All Covered Services, minus a \$10 Copayment	\$10 Copayment	All charges

(Covered Services for cleft lip and cleft palate treatment for children are listed on the following page)

Covered Services, Continued

Cleft lip and cleft palate treatment and services for children (continued)

In accordance with Massachusetts law, the following services are covered for *Members* under age 18. Services must be prescribed by the treating physician or surgeon, who must certify that they are *Medically Necessary* services required because of cleft lip or cleft palate.

Covered Services include:

- Medical and facial surgery: Coverage is provided for *Day Surgery* and *Inpatient* hospital admissions. This includes surgical management and follow-up care by plastic surgeons.
- Oral surgery, including surgical management and follow-up care by oral surgeons. **No referral is required from the child's PCP.**
- Dental surgery or orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy
- Speech therapy and audiology services
- Nutrition services

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR TUFTS HP PCP		CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP*
	The Plan Pays...	You Pay...	You Pay...
Methadone maintenance or methadone treatment related to substance use disorders	All Covered Services	Nothing	All charges

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)			
Benefit	CARE AUTHORIZED BY YOUR <i>PCP</i>		CARE NOT AUTHORIZED BY YOUR <i>PCP</i>
	The <i>Plan</i> Pays...	You Pay...	You Pay...
Hospice care	All <i>Covered Services</i>	Nothing	All charges

In addition to your hospice care benefits under Medicare, the *Plan* also covers the following services for terminally ill *Members* with a life expectancy of 6 months or less:

- *Provider* services
- Nursing care provided by or supervised by a registered professional nurse
- Social work services
- Volunteer services
- Counseling services (including bereavement counseling services for the *Member's* family for up to one year following the *Member's* death)

For the purposes of this benefit, “hospice care services” are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member*. Such services can be provided at home; on an *Outpatient* basis; and/or on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems that cannot (for medical reasons) be managed in a home setting.

Other Covered Services (outside of Medicare Parts A and B) (continued)

Tufts Health Plan Member Discounts

In addition to your covered benefits, as a *Member* you may take advantage of *Tufts Health Plan Member* Discounts. These include discounts on:

- Fitness center memberships;
- Nutritional supplements;
- Mind and body treatments; and
- A variety of services related to good health.

This list of *Member* discounts is effective January 1, 2016 and may change during the year. Please see our website at tuftshealthplan.com for the most current list or call a Member Specialist.

Current discounts include:

• **Fitness discounts**

- ❖ Save 20% on annual memberships and pay no initiation fee at the 80 *Tufts Health Plan* network health and fitness centers in Massachusetts, New Hampshire, and Rhode Island.
- ❖ Save 50% when you join a participating New England Curves® club.
- ❖ Save 10% on personal training packages at Fitness Together and receive a free initial fitness evaluation.
- ❖ Save 20% on Appalachian Mountain Club membership rates and receive discounts on accommodations, subscriptions, and programs.
- ❖ *Members* 18 and under pay no membership fee to enroll at participating Boys & Girls Clubs in Massachusetts and Rhode Island, and save 20% on the cost of most programs.
- ❖ As an alternative to annual memberships, you and your family can visit a fitness center in the *Tufts Health Plan* network up to five visits a month and pay a small copayment (\$6 - \$10) for each visit.

(continued on next page)

Other Covered Services (outside of Medicare Parts A and B) (continued)

Tufts Health Plan Member Discounts, continued

• **Fitness Club Rebate**

Your Plan includes \$150 mail-in fitness rebate for using a qualified fitness club (one that offers cardio and strength-training machines and other programs for improved physical fitness). To receive this rebate, you must complete at least four consecutive months of membership in *Tufts Health Plan* and at a qualified fitness center. Then, submit the Fitness Rebate Form, along with proof of fitness center membership and proof of payment, and we will reimburse up to \$150 of your fitness club fees for the year.

Note: The rebate applies once per person, per year, after you have incurred up to **\$150** of fitness club membership fees and have met the eligibility requirements. The fitness reimbursement is paid to the *Tufts Health Plan Subscriber*.

• **Nutritional Services**

- ❖ Unlimited Nutritional Counseling –In addition to your health plan coverage for *Medically Necessary* nutritional counseling, *Members* can receive 25% off the cost of unlimited visits with a registered dietitian or licensed nutritionist in our network.
- ❖ Dietary and Nutrition Supplements -- Save 15% or more on a wide variety of vitamins, supplements, and popular energy and protein bars through **ChooseHealthy.com**. *Members* also receive free standard shipping.

(continued on next page)

Other Covered Services (outside of Medicare Parts A and B) (continued)

Tufts Health Plan Member Discounts, continued

• **Mind and Body**

- ❖ Acupuncture and Massage Therapy – For acupuncture treatments, *Members* save 25 % off of the provider’s usual and customary rates. For massage therapy, *Members* pay the lesser of either (a) \$15 per 15 minutes, or (b) the provider’s usual and customary rates, minus a 25% discount. To find a participating provider, click on Member Discounts at **tuftshealthplan.com**.
- ❖ Hospital-Based Health and Wellness Seminars – Save up to 30% on wellness seminars and workshops at participating facilities. Topics include smoking cessation, stress management, aging, and parenting.
- ❖ Natural Therapies – Learn more about aromatherapy, homeopathic remedies, meditation, yoga, and other natural remedies at **ChooseHealthy.com**.
- ❖ Mindfulness Stress Reduction Program – *Members* can save 15% on the cost of tuition for the 8-week stress reduction program at UMass Medical School’s Center for Mindfulness in Medicine, Health Care and Society. The Center for Mindfulness (at the Shrewsbury campus) is a leader in mind-body medicine and mindfulness-based treatment and research. *Members* can access the discount at **umassmed.edu/cfm/stress-reduction/tufts-health-plan**.

• **Eyewear**

- ❖ *Members* can receive 35% off the retail price of frames, and discounted lenses and lens options, with the purchase of a complete pair of eyeglasses or prescription sunglasses from a participating EyeMed Vision Care provider.
- ❖ EyeMed also offers a contact lens replacement program; 20% off the retail price of nonprescription sunglasses; and 15% off the retail price (or 5% off the promotional price) of LASIK and PRK laser vision correction.

• **Home Instead Senior Care**

- ❖ *Members* receive a \$100 one-time credit (through participating offices) towards non-medical home care services, such as light housekeeping or meal preparation, provided to you or an elderly family member.
- ❖ Once you contract for services, you receive a free home-safety inspection, including a review of the home entrance, kitchen, bathrooms, and more.

Other Covered Services (outside of Medicare Parts A and B) (continued)

Tufts Health Plan Member Discounts, continued

- **Memory Fitness Activities Discount Program:**

Members can save 17% on a subscription to Posit Science’s BrainHQ program. BrainHQ is an application that is designed to improve information processing, information representation, memory, and learning. *Members* access the discount at brainhq.com/reg/thp

- **Other discounts**

- ❖ CVS Caremark ExtraCare health card – Receive 20% off the price of certain CVS/pharmacy-brand non-prescription health related items by using your ExtraCare health card offered by CVS Caremark (in conjunction with *Tufts Health Plan*).
- ❖ Jenny Craig – Get 50% off the enrollment fee for Jenny Craig’s AllAccess program, plus 5% off all Jenny Craig food. (Additional monthly membership fees and shipping costs are not included.) To access your discount, visit jennycraig.com/orgcode=THP.
- ❖ Nutrisystem – Save 12% off every 28-day Nutrisystem My Way® program order. My Way® is a metabolism and lifestyle based weight loss program. *Members* also receive a free Fast 5™ kit, which is designed to help you lose five pounds in your first week.
- ❖ The Original Healing Threads™ Designer Wear – Save 20% off machine-washable microfiber tops and breakaway pants that are treated to allow liquids to roll off of the fabric.
- ❖ iDiet: *Members* can receive a 15% discount for enrolling in the iDiet, an easy-to-follow 12-week program for healthy, long-term weight loss. For more information or to register for the *Plan* and automatically save 15%, go to myidiet.com/hi/tuftshealth.

These discounts and savings may change over time without notice. To check on current *Tufts Health Plan Member Discounts*, visit tuftshealthplan.com or call Member Services at 800-870-9488.

Other Covered Services (outside of Medicare Parts A and B) (continued)

PRESCRIPTION DRUGS COVERED BY MEDICARE PARTS A AND B

Prescription Drugs Covered By Medicare: Medicare provides coverage for certain prescription drugs, including certain injectable medications, when those drugs are obtained and administered by a physician to treat specific medical conditions. The physician will bill Medicare, and if the drug meets Medicare's coverage guidelines, Medicare will pay 80% of the Medicare approved charge for that drug. The *Plan* will then pay the remainder of the Medicare approved amount for the drug.

Medically Necessary hypodermic needles and syringes required to inject these medications are covered under the Prescription Drug Benefit.

Note: Home infusion (infused medications administered in the home setting) is not covered under the TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payer. *Tufts Health Plan* will then pay the remainder of the Medicare allowed amount.

For more information about this benefit, call Member Services at 800-870-9488.

Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR ALL OTHER PRESCRIPTION DRUGS

This section of the Prescription Drug Benefit describes coverage for all other prescription drugs under this TMC plan, including certain injectable drugs not covered by Medicare.

HOW PRESCRIPTION DRUGS ARE COVERED

Prescription drugs are *Covered Services* only they comply with the Pharmacy Management Programs section (below) and are:

- Listed under “What is Covered” (below)
- Provided to treat an injury, illness, or pregnancy
- *Medically Necessary*
- Written by a Plan participating physician, except in cases of authorized referral or *Emergency*

For a current list of covered drugs, please go to the *Plan’s* website at tuftshealthplan.com or call Member Services at 800-870-9488.

For a list of non-covered drugs, please see Appendix B.

The Prescription Drug Coverage Table below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest *Copayment*. Many generic drugs are on Tier-1.
- Tier-2 drugs have the middle *Copayment*.
- Tier-3 drugs have the highest *Copayment*.

Notes: Orally administered anticancer medications are covered in full.

Contraceptive coverage under the Affordable Care Act is as follows:

- Covered in full: generic versions of oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law, as well as brand name oral contraceptives, diaphragms, and other hormonal contraceptives with no generic equivalent.
- Cost Sharing Amount: Brand name drugs with a generic equivalent. However, if your physician attests that you require the brand name contraceptive because the generic alternative is not medically appropriate for you, then the brand name contraceptive will be covered in full.

Note: Italicized words are defined in the Glossary in Appendix A.

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR ALL OTHER PRESCRIPTION DRUGS (continued)

WHERE TO FILL PRESCRIPTIONS

You can fill your prescriptions at any Plan-designated pharmacy. For the majority of prescriptions, this includes most pharmacies in Massachusetts and additional pharmacies nationwide. For a select number of drug products, you must fill your prescription through a small number of specially-designated pharmacies. (For more information about *Tufts Health Plan's* special designated pharmacy program, see "Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.)

Note: Your prescription drug benefit is honored only at Plan-designated pharmacies. For information about reimbursement for your prescription drug claims in cases of *Emergency*, or about where to fill your prescription, please call Member Services at 800-870-9488.

HOW TO FILL PRESCRIPTIONS

Make sure the prescription is written by a participating Plan physician, except in cases of authorized referral or an *Emergency*. When you fill a prescription, **provide your Member ID card to any Plan designated pharmacy.**

If the retail cost of your prescription is less than your *Copayment*, then you are only responsible for the actual retail cost.

FILLING PRESCRIPTIONS FOR MAINTENANCE MEDICATIONS

If you take any maintenance medications, the *Plan* offers you two choices for filling your prescriptions:

- Directly from a Plan designated retail pharmacy; or
- Mailed to you through a Plan-designated mail services pharmacy (applies to most, but not all, maintenance medications). Plan-designated mail services pharmacies may not offer:
 - Medications for short-term medical conditions
 - Certain controlled substances and other prescribed drugs subject to exclusions or restrictions
 - Medications that are part of the *Plan's* Quantity Limitations or Special Designated Pharmacy programs

Note: Your *Copayments* for maintenance medications are shown in the Prescription Drug Coverage Table below.

Other Covered Services, Continued

Your **Prescription Drug Benefit** includes covered prescription drugs (including both acute and maintenance drugs) obtained directly from a *Tufts HP* designated retail pharmacy. *Tufts HP* pays all *Covered Services*, except the applicable *Copayment*, for these drugs.

You pay all charges for prescription drugs that do not qualify as *Covered Services*.

COVERAGE FOR ALL OTHER PRESCRIPTION DRUGS (continued)		
PRESCRIPTION DRUG COVERAGE TABLE		
Prescription Drug Benefit	<i>Tufts HP</i> Pays...	You Pay...
DRUGS OBTAINED AT A RETAIL PHARMACY Up to a 30-day supply	All <i>Covered Services</i> , except for the applicable <i>Copayment</i>	<u>Tier-1 drugs</u> : \$10 <i>Copayment</i> <u>Tier-2 drugs</u> : \$30 <i>Copayment</i> <u>Tier-3 drugs</u> : \$65 <i>Copayment</i>
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY Up to a 90-day supply	All <i>Covered Services</i> , except for the applicable <i>Copayment</i>	<u>Tier-1 drugs</u> : \$25 <i>Copayment</i> <u>Tier-2 drugs</u> : \$75 <i>Copayment</i> <u>Tier-3 drugs</u> : \$165 <i>Copayment</i>

If the retail cost of your prescription is less than your *Copayment*, then you are only responsible for the actual retail cost.

Note: If you fill your prescription in a state that allows you to request a brand name drug even though your physician authorizes the generic equivalent, you will pay the applicable Tier *Copayment* **plus** the difference in cost between the brand-name drug and the generic drug.

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR OTHER PRESCRIPTION DRUGS (continued)

WHAT IS COVERED UNDER YOUR PRESCRIPTION DRUG BENEFIT

- Prescribed drugs that by law require a prescription and are not listed under “What is Not Covered” (below)
- Diabetes supplies, including insulin, insulin pens, and insulin needles and syringes; oral diabetes medications (hypoglycemics); and urine glucose and ketone monitoring strips.
 - See Part B – Benefits (page 43) for information about your coverage for lancets and blood glucose strips, when provided by your Medicare Benefit instead of the *Plan’s* Prescription Drug Benefit.
- Hormone replacement therapy for peri- and post-menopausal women
- Acne medications for *Members 25* and under
- Oral contraceptives, diaphragms, Depo-Provera, and other hormonal contraceptives (e.g., patches, rings) that legally require a prescription and that are not mandated benefits under the Affordable Care Act.
 - See “*Outpatient Contraceptive Services*” (page 48) for information about other contraceptive drugs and devices that qualify as *Covered Services* under the Affordable Care Act.
 - In certain circumstances, Depo-Provera may qualify as a *Covered Service* under the “*Outpatient Contraceptive Services*” benefit.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter (with a prescription))
- Off-label use of FDA-approved prescription drugs to treat cancer or HIV/AIDS, provided that at least one of the following recognizes the drug for such treatment:
 - One of the standard reference compendia
 - The medical literature
 - The Massachusetts commissioner of insurance
- Compounded medications if, by law, at least one active ingredient requires a prescription
- Prescription and over-the-counter (with a prescription) smoking cessation agents

Note: Certain prescription drugs products may be subject to one of the Pharmacy Management Programs described below.

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR OTHER PRESCRIPTION DRUGS (continued)

WHAT IS NOT COVERED UNDER YOUR PRESCRIPTION DRUG BENEFIT

- Homeopathic medications
- Drugs that, by law, do not require a prescription (unless listed as covered in the “What is Covered” section above)
- Drugs that are listed in Appendix B (“Non-Covered Drugs with Suggested Alternatives”) at the end of this Evidence of Coverage
 - For additional information, see “Pharmacy Management Programs” and “Important Notes” later in this chapter, or call Member Services.
- Vitamins and dietary supplements (except prescription prenatal vitamins)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- *Experimental* drugs
- Prescriptions written by physicians who do not participate in the *Plan*, except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than Plan designated pharmacies, except for *Emergency* care
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency
- Acne medications for individuals 26 years and older, unless *Medically Necessary*
- Drugs dispensed in an amount or dosage that exceeds the *Plan*’s established quantity limitations
- Compounded medications, if no active ingredients legally require a prescription
- Prescriptions filled through an internet pharmacy, unless it is a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy
- Oral non-sedating antihistamines

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Covered Services, Continued

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR OTHER PRESCRIPTION DRUGS (continued)

WHAT IS NOT COVERED UNDER YOUR PRESCRIPTION DRUG BENEFIT (continued)

- Prescription medications that are available over-the-counter,
 - Both the specific medication and the entire class of prescription medications may not be covered.
- Prescription medications packaged with non-prescription products
- Prescription medications when therapeutically equivalent medications with the same active ingredient (or a modified version of an active ingredient) are available over-the-counter
 - Both the specific medication and the entire class of prescription medications may not be covered.
 - Excluded medications include, but are not limited to: topical acne medications with benzoyl peroxide $\leq 10\%$; H₂ blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, call Member Services or visit tuftshealthplan.com.
- Certain drugs and products are not covered under your prescription drug benefit but may be covered elsewhere under the *Plan*. These services include:
 - Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera (may be provided under your *Outpatient* care benefit (page 48))
 - Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products
 - Immunization agents (may be provided under *Preventive* health care on page 38)

Other Covered Services (outside of Medicare Parts A and B) (continued)

COVERAGE FOR OTHER PRESCRIPTION DRUGS (continued)

PHARMACY MANAGEMENT PROGRAMS

In order to provide safe, clinically appropriate, and cost-effective medications under this Prescription Drug Benefit, the *Plan* has developed the following Pharmacy Programs and Initiatives:

Quantity Limitations Program: The *Plan* limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program: The *Plan* restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from the *Plan* for such drugs.

Step Therapy PA Program: Step therapy is a type of prior authorization program (usually automated) that uses a step-wise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first, before other medications may be covered. *Members* must first try one or more medications on a lower step to treat a certain medical condition before a medication on a higher step is covered for that condition.

Notes:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the Pharmacy Management Programs described above, he or she may submit a request for coverage. The *Plan* will approve the request if it meets our guidelines for coverage. Please call Member Services at 800-870-9488 for more information.
- If a request is made to cover medications that are part of the “New-to-Market Drug Evaluation Process” program or the “Non-Covered Drugs with Suggested Alternatives” program, and that request is approved by *Tufts Health Plan*, the medications will be generally covered on the highest tier (e.g., Tier 3 on a 3-tier formulary, Tier-4 on a 4-tier formulary), with some exceptions. Please call Member Services at 800-870-9488 for more information.
- The *Plan*’s website lists covered drugs and their tiers. The *Plan* may change a drug’s tier during the year. For example, if a brand drug’s patent expires, the *Plan* may (a) move the brand drug from tier 2 to tier 3; or (b) add the brand drug to our list of non-covered drugs (see Appendix C) when a generic alternative becomes available. (Many generic drugs are available on tier 1.)
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check tuftshealthplan.com or call Member Services at 800-870-9488.

Exclusions from Benefits

The Plan will not pay for a service, supply, or medication that is:

- Not *Medically Necessary*
- Not a *Covered Service*
- Received outside the *Service Area*, except as described in “How the *Plan Works*” in Chapter 1
- Not essential to treat an injury, illness, or pregnancy (except for preventive care services)
- Able to be safely and effectively provided to you via a (a) less intensive level of service, supply, setting, or medication, or (b) more cost-effective alternative
- Primarily for your, or another person’s, personal comfort or convenience
- *Custodial Care*
- Related to a non-covered service
- A drug, device, medical treatment, or procedure (collectively "treatment") that is *Experimental or Investigative*, or for any related treatments

Note: This exclusion does not apply to the following services, as per Massachusetts law: bone marrow transplants for breast cancer; patient care services provided pursuant to a qualified clinical trial; or the off-label use of prescription drugs to treat cancer or HIV/AIDS.

- Drugs, medicines, materials, or supplies for use outside the hospital or any other facility (except as described in the Prescription Drug Benefit section (pages 64 through 71))
- Medications and other products that can be purchased without a prescription (except those listed as covered under the Prescription Drug Benefit)
- Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory
- Injectable medication (except as described on page 64)
- Infused medications and their administration in the home setting (home infusion), unless Medicare covers the infused medication and/or its administration as the primary payer. In that case, *Tufts Health Plan* will cover any remainder of the cost up to the Medicare allowed amount.
- Provided by an immediate family member (by blood or marriage), even if the relative is a *Plan Provider* and the services are authorized by your *PCP*. If you are a *Plan Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP* of a member of your immediate family (by blood or marriage).
- Required by a third party (i.e., employer, insurance company, school, or court) and not otherwise *Medically Necessary*
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.

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Exclusions from Benefits, Continued

- Care for conditions that state or local law requires be treated in a public facility
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated)
- Facility charges or related services for a non-*Covered Service*
- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery (except as provided under “dental services” on page 39); alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders.

Note: This exclusion does not apply to the treatment of cleft lip or cleft palate for *Members* under 18, as described under “Cleft lip or cleft palate treatment and services for *Children*” earlier in this chapter.

- Surgical removal or extraction of teeth (except as provided under “dental services” on page 39)
- Cosmetic (i.e., meant to change or improve appearance) services, including surgery, procedures, supplies, medications, and appliances.

Note: Breast reconstruction is covered when following a *Medically Necessary* mastectomy, as described in “Hospital *Inpatient* Services (Part A) (page 28).

- Rhinoplasty; liposuction; and brachioplasty
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition
- Costs associated with home births
- Human organ transplants, if not covered by Medicare
- The purchase of an electric hospital-grade breast pump
- Services provided to a non-*Member*
- Over-the-counter contraceptive agents
- Acupuncture; biofeedback (except to treat urinary incontinence); hypnotherapy; psychoanalysis; neuromuscular stimulators and related supplies; electrolysis; any type of thermal therapy device; *Inpatient* and *Outpatient* weight-loss programs and clinics exercise classes; relaxation therapies; massage therapies (except as covered physical therapy services); services by a personal trainer; exercise classes; cognitive rehabilitation programs; cognitive retraining programs; and diagnostic services related to any of these procedures or programs.

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Exclusions from Benefits, Continued

- Infertility services, infertility medications and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to:
 - *Experimental* infertility procedures
 - The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member*.
 - A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.
 - A gestational carrier is a surrogate with no biological connection to the embryo/child.
 - Reversal of voluntary sterilization
 - Sperm or embryo cryopreservation
 - Donor recruitment fee for donor egg or donor sperm
 - Donor sperm and associated laboratory services
 - Costs associated with donor recruitment and compensation
 - Infertility services that are necessary for conception as a result of voluntary sterilization or after an unsuccessful reversal of a voluntary sterilization
- Preimplantation genetic testing and related procedures performed on gametes or embryos
- Treatments, medications, procedures, services and supplies related to reversal of voluntary sterilization
- Devices and procedures intended to reduce snoring, including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PADs), tablets, and smartphones; accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries, etc.); Internet and modem connection/access (e.g., Wi-Fi®, Bluetooth®, Ethernet and all related accessories).
- Alternative, holistic, naturopathic, and/or functional health medicine services, supplies, procedures, labs and supplements
- Services, programs, supplies, or procedures performed in a non-conventional setting (including, but not limited to, spas/resorts, educational, vocational, or recreational settings; daycare or preschool settings; Outward Bound; or wilderness , camp or ranch programs clinics), even if performed or provided by a licensed *Provider*. Examples of excluded services provided in a non-conventional setting include psychotherapy, ABA services, and nutritional counseling.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi (except as described in “Ambulance Services” on page 41)
- Lodging related to receiving any medical service

Exclusions from Benefits, Continued

- Blood, blood donor fees, blood storage fees, or blood substitutes; blood banking, cord blood banking and blood products

Note: This exclusion does not apply to the following blood services and products:

- Blood processing
- Blood administration
- Monoclonal and recombinant Factor products for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required)
- Intravenous immunoglobulin to treat severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required)
- Examinations, evaluations or services for educational or *Developmental* purposes, including physical therapy, speech therapy, and occupational therapy (except as provided on page 40); vocational rehabilitation services and vocational retraining; services to treat learning disabilities, behavioral problems, and *Developmental* delays; services to treat speech, hearing and language disorders in a school-based setting.
- Eyeglasses, lenses or frames; contact lenses or contact lens fittings; or refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery
- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet.

Note: This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes. It also does not apply to therapeutic/molded shoes and shoe inserts for *Members* with severe diabetic foot disease, when (1) the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and (2) the shoes and inserts are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

Chapter 4

When Coverage Ends

REASONS COVERAGE ENDS

This chapter tells you when coverage ends.

Reasons coverage ends

- Loss of eligibility due to:
 - No longer meeting the *Group Insurance Commission's* or the *Plan's* eligibility rules
 - No longer being enrolled in Parts A and B of Medicare (please refer to your Medicare Handbook for events that can change your Medicare coverage), or
 - Moving out of the *Service Area* (see below)
- You choose to drop your coverage under the *Plan* (during Annual Enrollment or due to a qualifying event)
- Commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to: any *Provider*; any *Member*; or the *Plan* or any Plan employee
- Misrepresentation of information or fraud
- Failure to pay the required *Premium*
- The *Group Insurance Commission's* contract with the *Plan* ends

If you move out of the *Service Area*

If you move out of the *Service Area*, coverage ends the last day of the month in which you move. If you keep a residence in the *Service Area* but have been out of the *Service Area* for more than 90 days, coverage ends 90 days after the date you left the *Service Area*.

Call Member Services at 800-870-9488 before you move to notify the *Plan*.

For more information about coverage options available to you when you move out of the *Service Area*, contact the *Group Insurance Commission* at 617-727-2310, ext. 1.

Acts of physical or verbal abuse

The *Plan* may terminate your coverage if you commit acts of physical or verbal abuse that:

- Are unrelated to your physical or mental condition; and
- Pose a threat to a *Provider*, *Member*, Plan employee, or the *Plan* itself.

Note: Italicized words are defined in Appendix A.

When Coverage Ends, continued

REASONS COVERAGE ENDS, continued

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

- False or misleading information on your application
- Enrolling someone who is not your *Spouse* as a *Spouse*
- Receiving benefits for which you are not eligible
- Keeping payments made by *Tufts Health Plan* and intended to be used to pay a *Provider* for yourself
- Submission of any false paperwork, forms, or claims information
- Allowing someone else to use your Member ID card

If *Tufts Health Plan* terminates your coverage for misrepresentation or fraud, your coverage will end as of your *Effective Date* or a later date chosen by the *Plan*. *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as a nongroup plan or another employer's plan) or type of coverage (for example, coverage as a *Spouse*).

End of the relationship between the *Plan* and the *Group Insurance Commission*

Coverage will terminate if the relationship between the *Group Insurance Commission* and the *Plan* ends for any reason, including

- The *Group Insurance Commission's* contract with the *Plan* terminates.
- The *Group Insurance Commission* fails to pay *Premiums* on time.
- The *Plan* stops operating.
- The *Group Insurance Commission* stops operating.

When Coverage Ends, continued

BENEFITS AFTER TERMINATION

The *Plan* will not pay for services you receive after your coverage ends, even if either of the following applies:

- You were receiving *Inpatient* or *Outpatient* care when your coverage ends
- There is an existing medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends

PAYMENT OF CLAIMS

Tufts Health Plan will pay for all *Covered Services* you received between your *Effective Date* and your termination date, as chosen by the *Plan*. *Tufts Health Plan* may retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

Tufts Health Plan will use any *Premium* you paid for a period after your termination date to pay for *Covered Services* you received after your termination date. If the *Premium* is not enough to pay for that care, *Tufts Health Plan* may:

- Pay the *Provider* for those services and ask you to reimburse *Tufts Health Plan*; or
- Not pay for those services. In this case, you will have to pay the *Provider* for the services.

If the *Premium* is more than is needed to pay for *Covered Services* you received after your termination date, *Tufts Health Plan* will refund the excess to the *Group Insurance Commission*.

VOLUNTARY AND INVOLUNTARY DISENROLLMENT RATES FOR MEMBERS

As required by Massachusetts law, the *Plan* conducts an annual disenrollment study. The study looks at the reasons *Members* leave *Tufts Health Plan* in order to track voluntary and involuntary disenrollment rates.

- **Voluntary Disenrollment Rate** - The number of *Members* the *Plan* disenrolled because they ceased to pay *Premiums*. This is the voluntary disenrollment rate. For the year 2015, less than one percent of *Members* voluntarily disenrolled by ceasing to pay their *Premiums*.
- **Involuntary Disenrollment Rate** - The number of *Members* that the *Plan* disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2015, less than one percent of *Members* were involuntarily disenrolled as a result of fraud or abuse.

For additional information, please call Member Services at 800-870-9488.

Chapter 5

Member Satisfaction

Member Satisfaction Process

The *Plan* has a multi-level *Member* Satisfaction process including:

- Internal Inquiry
- *Member* Grievances Process
- Internal *Member* Appeals
- External Review by the Massachusetts Office of Patient Protection

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to Member Services at **800-870-9488**.

Internal Inquiry

Call a Member Services Coordinator to discuss any concerns regarding your healthcare. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be resolved within three (3) business days, or if you tell a Member Services Coordinator that you are not satisfied with the response you have received from *Tufts HP*, the *Plan* will send you a letter describing your options, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accord with the timelines outlined below.

Tufts HP maintains records of each inquiry made by a *Member* or by that *Member's* authorized representative. The records of these inquiries and the response provided by *Tufts HP* are subject to inspection by the Massachusetts Commissioner of Insurance and the Health Policy Commission's Office of Patient Protection.

Important Notes about Appeals and Grievances:

- In many instances, we will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or on the official Medicare website at medicare.gov.
- The Member Satisfaction Process described below applies to you when we determine that a service under this plan (and not under Medicare) is *Medically Necessary*.

Note: Italicized words are defined in Appendix A.

Member Satisfaction Process, Continued

Member Grievance Process

A grievance is a formal complaint about actions taken by *Tufts HP* or a *Provider*. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concerns.

Appeals may be filed either verbally or in writing. To file a verbal appeal, call Member Services at 800-870-9488; a Member Services Coordinator will document your concerns and forward a report to the Appeals and Grievance Department. However, we suggest you file a written grievance to more accurately explain your concerns. Send it to the address provided at the beginning of this section and include:

- Your name and address;
- Your Member ID number;
- A detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- Any supporting documentation.

Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the “Internal *Member* Appeals” section below.

Member Satisfaction Process, Continued

Administrative Grievances

- If you file your grievance in writing, we will confirm receipt of your letter within five (5) business days of receipt. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within 48 hours. In both cases, we will provide you with the name, address, and telephone number of the person coordinating your grievance review.
- If your request for review was first addressed through the internal inquiry process and does not require medical records review, the 30-calendar day review period will begin the day following the end of the three (3)-business day internal inquiry process. It may begin earlier if you notify *Tufts HP* that you are not satisfied with the response you received during the internal inquiry process.
- If your grievance requires medical records review, *Tufts HP* will send you an Authorization for Release of Health Information form that allows your *Providers* to release medical information relevant to your grievance to the *Plan*. **You must sign and return the form before *Tufts HP* can begin the review process.** If you do not sign and return the form to *Tufts HP* within 30 business days of the date you filed, *Tufts HP* may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are possessed and controlled by *Tufts HP*.
- *Tufts HP* will review your grievance and send you a letter regarding the outcome, as allowed by law, within 30 calendar days of receipt.

Upon mutual written agreement between you (or your authorized representative) and *Tufts HP*, the time limits in this process may be waived or extended beyond the time allowed by law.

Member Satisfaction Process, Continued

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your *Provider*. If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider*, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will confirm receipt of your letter within five (5) business days of receipt. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within 48 hours. In both cases, we will provide you with the name, address, and telephone number of the person coordinating your grievance review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within 30 calendar days of receipt. The review period may be extended up to an additional 30 days if additional time is needed to complete the review. You will be notified in writing if the review timeframe is extended.

Recon-Sideration

If you are not satisfied with the result of the Clinical Grievance review process, you may request a reconsideration by a clinician who was not involved in the initial review process. Your concerns will be reviewed within 30 calendar days of your request for a reconsideration. You will be notified in writing of the results of the review.

Internal Member Appeals

An appeal is a request for review of a denial of coverage made by *Tufts HP* due to (1) failure to meet medical necessity criteria (an adverse determination); or (2) a specifically excluded service or supply. It is important that you contact *Tufts HP* as soon as possible to explain your concerns. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal.

Appeals may be filed either verbally or in writing. To file a verbal appeal, call Member Services at 800-870-9488. However, we suggest you file a written grievance to more accurately explain your concerns. Send it to the address provided at the beginning of this section and include:

- Your name and address;
- Your Member ID number;
- A detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- Any supporting documentation.

The *Tufts Health Plan* Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this *Evidence of Coverage*.

Appeals Timeline

We will provide written confirmation of your verbal or written appeal, and of our understanding of your concerns, within 48 hours of receipt. We will also provide you with the name, address, and telephone number of the person coordinating your grievance review.

- If your request for review was first addressed through the internal inquiry process and does not require the review of medical records, the 30-calendar day review period will begin the day following the end of the three (3)-day internal inquiry process. It may begin earlier if you notify *Tufts HP* that you are not satisfied with the response you received during the internal inquiry process.
- If your appeal requires medical records review, *Tufts HP* will send you an Authorization for Release of Health Information form, which authorizes your *Providers* to release medical information relevant to your Appeal to the *Plan*. **You must sign and return the form before *Tufts HP* can begin the review process.** If you do not sign and return the form within 30 calendar days of the date you filed your appeal, *Tufts HP* may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal that are possessed and controlled by *Tufts HP*.
- *Tufts HP* will review your appeal, make a decision, and send you a regarding the outcome within 30 calendar days of receipt.

The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and *Tufts HP*. This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The person handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

Member Satisfaction Process, Continued

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing health care professional who did not participate in any of the prior decisions on the case will take part in the review. This *Provider* must practice in the same (or similar) specialty that typically treats the medical condition, performs the procedure, or provides the treatment under review. In addition, a committee of managers and clinicians from various *Tufts HP* departments will also review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters

The letter you receive from *Tufts HP* will identify the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include the following information:

- The specific information upon which the adverse determination was based
- *Tufts HP's* understanding of your presenting symptoms or condition
- Diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria
- Alternative treatment options offered, if any
- Applicable clinical practice guidelines and review criteria
- The steps to request external review by the Office for Patient Protection
- The titles and credentials of the individuals who reviewed the case
- The availability of translation services and consumer assistance programs

Requests for coverage of services that are specifically excluded in your *Evidence of Coverage* (EOC) are not eligible for external review.

If *Tufts HP* does not properly act on your appeal within the time limits of Massachusetts law and regulations (including any extensions made by mutual written agreement between you and the *Plan*), the appeal will automatically be resolved in your favor.

Member Satisfaction Process, Continued

IF YOU ARE NOT SATISFIED WITH THE APPEALS DECISION

**“Recon-
sideration”**

In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, *Tufts HP* may allow reconsideration of a final adverse determination. If you request a reconsideration, you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

**External
Review by
The Office
of Patient
Protection**

The Office of Patient Protection (OPP) administers an independent external review process for final coverage determinations based on medical necessity (final adverse determinations). The OPP is not connected in any way with *Tufts HP*. Appeals for coverage of services specifically excluded in your EOC are not eligible for external review.

To request an external review by the Office of Patient Protection, you must file your request in writing with the OPP within four (4) months of your receipt of written notice of the denial of your appeal by Tufts Health Plan. The notification letter from the *Plan* will contain the forms and information you need to file this appeal. The review panel will make a decision within 45 days for standard reviews and within 72 hours for expedited reviews.

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a written certification from a physician, stating that a delay in the providing or continuation of the health care services subject to a final adverse determination would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify the request as eligible for an expedited external review.

An external review by the Office of Patient Protection costs \$25.00, which should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that payment would result in an extreme financial hardship to you. OPP will also refund the fee to the insured if the adverse determination is reversed in its entirety. Tufts Health Plan will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill Tufts HP the amount established pursuant to contract between the Department and the assigned external review agency minus the \$25 fee, which is your responsibility. You will not be required to pay more than \$75 per plan year, regardless of the number of external review requests submitted.

You, or your authorized representative, will have access to any medical information and records that Tufts HP has relating to your appeal.

Member Satisfaction Process, Continued

External Review by The Office of Patient Protection, continued

If the external review involves the termination of ongoing services, you may ask the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at *Tufts HP's* expense regardless of the final external review determination.

The decision of the review panel will be binding on *Tufts HP*. If the external review agency overturns a *Tufts HP* decision in whole or in part, *Tufts HP* will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

- Include an acknowledgement of the decision of the review agency;
- Advise you of any additional procedures for obtaining the requested coverage or services;
- Advise you of the date by which the payment will be made or the authorization for services will be issued by *Tufts HP*; and
- Include the name and phone number of the person at *Tufts HP* who will assist you with final resolution of the grievance.

If you are unhappy with Tufts HP's Member Satisfaction Process

Please note, if you are not satisfied with *Tufts HP's* member satisfaction process at any time, you have the right to contact the Health Policy Commission's Office of Patient Protection at:

Health Policy Commission, Office of Patient Protection
Two Boylston Street, 6th Floor, Boston, MA 02116
800-436-7757
Fax: 617-624-5046
ma.gov/hpc/opp
HPC-OPP@state.ma.us

You may also contact the Massachusetts Division of Insurance's Bureau of Managed Care at **617-521-7372** or **bmc.mailbox@state.ma.us**.

Bills from *Providers*

Medical Expenses

Occasionally, you may receive a bill from a *Provider* for *Covered Services*. Before paying the bill, contact the Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- A completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* Web site or by contacting Member Services; and
- The documents listed on the Member Reimbursement Medical Claim Form.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claim Form.

Send bill(s) to the *Plan* no later than twelve months after the date of service. If you do not submit them in this timeframe, bills cannot be considered for payment. Most completed reimbursement requests are processed within 4-6 weeks. Incomplete requests and requests for services provided outside of the U.S. may take longer.

If you receive *Covered Services* from a non-Plan *Provider* (i.e., *Emergency* or *Urgent Care* services), the *Plan* will pay you up to the *Reasonable Charge* for those services.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made due to *Tufts Health Plan's* error.

Pharmacy Expenses

If you obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting Member Services or through the *Plan's* website at tuftshealthplan.com.

Limitation on Actions

You cannot file a lawsuit against *Tufts Health Plan* for failing to pay or arrange for *Covered Service* unless you have completed the *Plan's* Member Satisfaction Process. You must file the lawsuit within two years of the time the cause of action began. For example, if you want to file a lawsuit because you were denied coverage, you must first complete our *Member* Satisfaction Process and then file suit within two years of **first** being sent a notice of the denial.

Going through the *Member* Satisfaction Process does not extend the time limit for filing a lawsuit beyond the two years after the date you were first denied coverage. However, if you pursue external review by the Office of Patient Protection, the days from the date your request is received by the OPP until the date you receive the response are not counted toward the two-year limit.

Chapter 6

Other *Plan* Provisions

Subrogation

**The *Plan's*
right of
subrogation**

You may have a legal right to recover some or all of the costs of your health care from someone else (a “Third Party”). “Third Party” means any person or company that is, or could be, responsible for the costs of injuries or illness to you.

Tufts Health Plan may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- Payments made by a Third Party
- Payments made by any insurance company on behalf of the Third Party
- Any payments or rewards under an uninsured or underinsured motorist coverage policy
- Any disability award or settlement
- Medical payments coverage under any automobile policy
- Premises or homeowners’ medical payments coverage
- Premises or homeowners’ insurance coverage
- Any other payments from a source intended to compensate you for Third Party injuries

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. *Tufts HP* can recover against the total amount of any recovery, regardless of whether

- All or part of the recovery is for medical expenses, or
- The recovery is less than the amount needed to reimburse you fully for the illness or injury.

**Personal Injury
Protection/Med
Pay Benefits**

You may be entitled to benefits under your own or another individual’s automobile coverage, regardless of fault. These benefits are commonly referred to as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. Our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

Note: Italicized words are defined in Appendix A.

Subrogation, Continued

Workers' Compensation Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law. (This is true whether or not the employer has obtained workers' compensation coverage as required by law.)

If the *Plan* pays for health care services for any work-related illness or injury, *Tufts HP* has the right to recover its costs. The *Plan* may recover those costs from you, the person or company legally obligated to pay for such services, or the *Provider*. If your *Provider* bills services to the *Plan* for any work-related illness or injury, please contact the Liability and Recovery Department at 888-880-8699, ext. 21098.

The *Plan's* right of reimbursement You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse *Tufts HP* for the cost of health care services, supplies, medications, and expenses for which *Tufts HP* paid or will pay.

This right of reimbursement attaches when we have provided health care benefits for expenses when (1) a Third Party is responsible, and (2) you have recovered any amounts from any sources. This includes, but is not limited to:

- Payments made by a Third Party
- Payments made by any insurance company on behalf of the Third Party
- Any payments or awards under an uninsured or underinsured motorist coverage policy
- Any disability award or settlement
- Medical payments coverage under any automobile policy
- Premises or homeowners' medical payments coverage
- Premises or homeowners' insurance coverage
- Any other payments from a source intended to compensate you when a Third Party is responsible

Tufts HP has the right to be reimbursed up to the amount of any payment received by you, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury. This provision applies in addition to the rights described above.

Subrogation, Continued

Member Cooperation

You further agree:

- To provide prompt written notification to the *Plan* when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- To cooperate with us and provide us with requested information;
- To do whatever is necessary to secure our rights of subrogation and reimbursement under this plan;
- To assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and any other expenses, that we paid or will pay for your illness or injury;
- To give us a first priority lien on any recovery, settlement, judgment or other source of compensation that any Third Party may have. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- To do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
- To serve as a constructive trustee for the benefit of this plan over any settlement or recovery funds received as a result of Third Party responsibility;
- That we may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise;
- That no court costs or attorney fees may be deducted from our recovery;
- That we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party without our prior express written consent; and
- That in the event you or your written representative fails to cooperate with *Tufts Health Plan*, you shall be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by *Tufts Health Plan* in obtaining repayment.

Constructive Trust

By accepting benefits from *Tufts Health Plan* (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a *Provider*), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to *Tufts Health Plan*.

Subrogation Agent

The *Plan* may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as the *Plan's* agent.

Coordination of Benefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

The *Plan* has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with state law.

Note: We coordinate benefits with Medicare according to federal law, rather than state law.

Primary and secondary plans

The *Plan* will coordinate benefits by determining

- Which plan has to pay first when you make a claim, and
- Which plan has to pay second

The *Plan* will make these determinations according to applicable state law.

Right to receive and release necessary information

When you complete your membership application, you must include information about other health coverage you have.

After you enroll, you must notify the *Plan* of new coverage or termination of other coverage. The *Plan* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the *Plan's* COB program.

Right to recover overpayment

The *Plan* may recover from you, or any other person or entity, any payments greater than what it should have made under the COB program. The *Plan* will only recover overpayments actually made.

For more information

For more information about COB, contact the *Plan's* Liability Recovery (COB) Department at 888-880-8699, ext. 21098.

Use and Disclosure of Medical Information

The *Plan* mails a separate “Notice of Privacy Practices” to all *Subscribers* to explain how the *Plan* uses and discloses your medical information. If you have questions or would like another copy of the “Notice of Privacy Practices”, please call Member Services at 800-870-9488. Information is also available on the *Plan’s* Web site at tuftshealthplan.com.

Relationships between the *Plan* and *Providers*

The *Plan* arranges health care services. The *Plan* does not provide health care services. The *Plan* has agreements with independent *Providers* practicing throughout the *Service Area*. These *Providers* are not *Plan* employees, agents or representatives. *Providers* are not authorized to change this *Evidence of Coverage* or assume or create any obligation for the *Plan*.

The *Plan* is not liable for the conduct of any *Provider*, including acts, omissions, representations or any other behavior.

Circumstances Beyond the *Plan’s* Reasonable Control

The *Plan* is not responsible for a failure or delay to arrange services due to circumstances beyond the reasonable control of the *Plan*. Such circumstances include, but are not limited to, major disaster, epidemic, strike, war, riot, and civil insurrection. In such circumstances, the *Plan* will make a good faith effort to arrange for the provision of services, taking into account the impact of the event and the availability of *Plan Providers*.

Group Contract

Acceptance of the terms of the Group Contract By signing and returning the membership application form, you apply for *Group* coverage and agree to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

Payments for coverage The *Plan* will bill the *Group Insurance Commission (GIC)*, which will pay *Premiums* to the *Plan* for you. The *Plan* is not responsible if the *GIC* fails to pay the *Premium*.

Note: If the *Group Insurance Commission* fails to pay the *Premium* on time, the *Plan* may cancel your coverage in accordance with the *Group Contract* and applicable state law.

The *GIC* may change the *Premium* on an annual basis. Any *Premium* change will apply to all *Members* enrolled in this *Group Insurance Commission* option.

Changes to this Evidence of Coverage The *Plan* may change this *Evidence of Coverage* subject to *GIC* approval. Changes do not require your consent. If changes are made, they will apply to all *Members*, not just to you.

Notice of changes in *Covered Services* will be sent to the *Group Insurance Commission* at least 60 days before the *Effective Date* of the modifications and will include:

- Information regarding any changes in clinical review criteria; and
- The effect of such changes on a *Member's* personal liability for the cost of the changes.

An amendment to this *Evidence of Coverage* will be sent to you describing the changes and the *Effective Date*. Changes will apply to all benefits for services received on or after the *Effective Date*.

Group Contract, Continued

Notice Notice to Members: We may send notice to you of information affecting your *Tufts Health Plan* coverage. Notices will be sent to the current address on file with us.

Notice to the Plan: *Members* should address all correspondence to:

Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472-1508

Enforcement of terms *Tufts HP* may choose to waive certain terms of the *Group Contract*, if applicable, including the *Evidence of Coverage*. This does not mean that *Tufts HP* gives up its rights to enforce those terms in the future.

When this Evidence of Coverage is Effective This *Evidence of Coverage* is effective July 1, 2016 and replaces all previous *Evidences of Coverage*.

Appendix A

Glossary of Terms

Terms and Definitions

The table below defines the terms used in this *Evidence of Coverage*.

Term	Definition
Annual Coverage Limitations	Annual dollar or time limits on <i>Covered Services</i> .
Authorized Reviewer	<i>Authorized Reviewers</i> review and approve certain services and supplies to <i>Members</i> . They are either the <i>Plan's</i> Chief Medical Officer (or equivalent), or someone he or she names to perform this function.
Benefit Period	<p>Medicare uses <i>Benefit Periods</i> to measure your use of hospital and <i>Skilled</i> nursing facility (SNF) services. A <i>Benefit Period</i> begins the day you go to a hospital or SNF and ends when you have not received hospital or SNF care for 60 days in a row. If you go into the hospital after one <i>Benefit Period</i> has ended, a new <i>Benefit Period</i> begins.</p> <p>You must pay the <i>Inpatient</i> hospital deductible for each <i>Benefit Period</i>. There is no limit to the number of <i>Benefit Periods</i> you can have.</p>
Board-Certified Behavior Analyst (BCBA)	A <i>Board-Certified Behavior Analyst (BCBA)</i> meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A <i>BCBA</i> professional conducts behavioral assessments, designs and supervises behavior analytic interventions; and develops and implements assessments and interventions for <i>Members</i> with diagnoses of autism spectrum disorders. <i>BCBAs</i> may supervise the work of other <i>BCBAs</i> and <i>Paraprofessionals</i> who implement behavior analytic interventions.

Terms and Definitions, Continued

Term	Definition
Coinsurance	<p>The percentage of costs you must pay for certain <i>Covered Services</i>.</p> <p>For services provided by a <i>Non-Plan Provider</i>, your share is a percentage of the <i>Reasonable Charge</i> for those services.</p> <p>For services provided by a <i>Plan Provider</i>, your share is a percentage of:</p> <ul style="list-style-type: none"> • the applicable <i>Plan</i> fee schedule amount for those services; and • the <i>Plan Provider's</i> actual charges for those services, <p>whichever is less.</p> <p>Costs in excess of the <i>Reasonable Charge</i> are not subject to <i>Coinsurance</i>. The <i>Member</i> is responsible for paying for costs in excess of the <i>Reasonable Charge</i>.</p>
Copayment	<p>Fees you pay for <i>Covered Services</i>. <i>Copayments</i> are paid to the <i>Provider</i> when you receive care unless the <i>Provider</i> arranges otherwise.</p>
Covered Services	<p>The services and supplies for which the <i>Plan</i> will pay. They must be</p> <ul style="list-style-type: none"> • described in Chapter 3; • <i>Medically Necessary</i>; and • given or authorized by your <i>PCP</i> and in some cases approved by an <i>Authorized Reviewer</i>.
Covering Physician	<p>The physician named by your <i>PCP</i> to give or authorize services in your <i>PCP's</i> absence.</p>

Terms and Definitions, Continued

Term	Definition
Custodial Care	<ul style="list-style-type: none"> • Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety; • Care given primarily for maintaining the <i>Member's</i> or anyone else's safety, when no other aspects of treatment require an acute hospital level of care; • Services that could be given by people without professional skills or training; or • Routine maintenance of colostomies, ileostomies, and urinary catheters; or • Adult and pediatric day care. <p>In cases of mental health care, <i>Inpatient</i> care given primarily</p> <ul style="list-style-type: none"> • for maintaining the <i>Member's</i> or anyone else's safety, or • for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute hospital level of care. <p>Note: <i>Custodial Care</i> is <u>not</u> covered by the <i>Plan</i>.</p>
Day Surgery	Any surgical procedure(s) provided to a <i>Member</i> at a facility licensed by the state to perform surgery, and with an expected discharge the same day. For hospital census purposes, the <i>Member</i> is an <i>Outpatient</i> , and not an <i>Inpatient</i> .
Deductible	The amount you must pay for health care, before Medicare begins to pay for Medicare <i>Covered Services</i> . There is a <i>Deductible</i> for each <i>Benefit Period</i> for Part A, and each year for Part B. These amounts can change every year.
Developmental	Refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that are not caused by an underlying medical illness or condition.

Terms and Definitions, Continued

Term	Definition
Directory of Health Care Providers	<p>A separate booklet which lists</p> <ul style="list-style-type: none"> • <i>Plan PCPs</i> and their affiliated <i>Plan Hospital</i>; and • Certain other <i>Plan Providers</i>. <p>Note: This booklet is updated from time to time to show changes in <i>Providers</i> affiliated with the <i>Plan</i>. For information about the <i>Providers</i> listed in the <i>Directory of Health Care Providers</i>, call Member Services at 800-870-9488 or check the <i>Plan's</i> website at tuftshealthplan.com.</p>
Durable Medical Equipment	<p>Devices or instruments of a durable nature that are:</p> <ul style="list-style-type: none"> • Reasonable and necessary to sustain a minimum threshold of independent daily living • Made primarily to serve a medical purpose • Not useful in the absence of illness or injury • Able to withstand repeated use • Used in the home
Effective Date	<p>The date, according to the <i>Plan's</i> records, that you become a <i>Member</i> and are first eligible for <i>Covered Services</i>.</p>
Emergency	<p>An illness or medical condition (whether physical, behavioral, related to a substance use disorder, or mental) that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:</p> <ul style="list-style-type: none"> • Serious jeopardy to the physical and/or mental health of a <i>Member</i>, another person, or a pregnant <i>Member's</i> unborn child; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part; or • With respect to a pregnant woman who is having contractions: inadequate time to safely transfer to another hospital before delivery, or a threat to the safety of the <i>Member</i> or her unborn child if they were transferred to another hospital before delivery. <p>Some examples of illnesses or medical conditions requiring <i>Emergency</i> care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, suicidality, or any medical condition that is quickly worsening.</p>
Evidence of Coverage	<p>This document and any future amendments.</p>

Terms and Definitions, Continued

Term	Definition
Experimental or Investigative	<p>A service, supply, treatment, procedure, device, or medication (collectively “treatment”) is considered <i>Experimental or Investigative</i> if any of the following is true:</p> <ul style="list-style-type: none"> • The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or • The treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or • Reliable evidence shows that the treatment: is the subject of ongoing Phase I or Phase II clinical trials; is the research, experiment, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis. • Reliable evidence shows that more studies or clinical trials are necessary to determine its safety, efficacy, and positive effects on health outcomes. • Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined. • The peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled, or cohort studies, or there are few or no well-designed randomized, controlled trials.

Terms and Definitions, Continued

Term	Definition
Group Contract	The agreement between <i>Tufts Health Plan</i> and the <i>Group Insurance Commission</i> under which <i>Tufts Health Plan</i> agrees to provide <i>Group Coverage</i> to you, and the <i>GIC</i> agrees to pay a <i>Premium</i> to the <i>Plan</i> on your behalf. The <i>Group Contract</i> includes this <i>Evidence of Coverage</i> and any amendments.
Group Insurance Commission	The Massachusetts state agency responsible for purchasing this health care program for employees and retirees of the Commonwealth of Massachusetts and <i>Participating Municipalities</i> . Also referred to as the <i>GIC</i> .”
Inpatient	A patient who is admitted to a hospital or other facility licensed to provide continuous care and classified as an <i>Inpatient</i> for all or a part of a day by that facility.
Medically Necessary	<p>A service or supply that is consistent with generally accepted principles of professional medical practice, as determined by whether that service or supply:</p> <ul style="list-style-type: none"> • The most appropriate available supply or level of services for the <i>Member</i> in question, considering potential benefits and harms to that individual; • Known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or • For services and interventions not in widespread use, is based on scientific evidence <p>In determining coverage for <i>Medically Necessary Services</i>, the <i>Plan</i> uses <i>Medical Necessity</i> coverage guidelines that are:</p> <ul style="list-style-type: none"> • Developed with input from practicing physicians in the <i>Service Area</i> • In accordance with the standards adopted by national accreditation organizations • Updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and • Evidence-based, if practicable <p>Note: For those services covered by Medicare, Medicare determines what is <i>Medically Necessary</i></p>

Terms and Definitions, Continued

Term	Definition
Member	A person enrolled in <i>Tufts Health Plan</i> under the <i>Group Contract</i> . Also referred to as "you."
Observation	The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) hours or a verified diagnosis and concurrent treatment plan. At times, an <i>Observation</i> stay may be followed by an <i>Inpatient</i> admission to treat a diagnosis revealed during the period of <i>Observation</i> .
Open Enrollment Period	The period each year when the <i>Group Insurance Commission</i> allows eligible persons to apply for group coverage under this plan and other health plans offered by the <i>GIC</i> .
Outpatient	A patient who receives care other than on an <i>Inpatient</i> basis. This includes services provided in a physician's office, a <i>Day Surgery</i> or ambulatory care unit, an <i>Emergency</i> room, or an outpatient clinic.
Paraprofessional	As it pertains to the treatment of autism and autism spectrum disorders, a <i>Paraprofessional</i> is an individual who performs applied behavioral analysis (ABA) services under the supervision of a <i>Board-Certified Behavior Analyst (BCBA)</i> .
Participating Municipality	A city, town or district in the Commonwealth of Massachusetts that participates in the insurance plan offered by the <i>Group Insurance Commission</i> .
The <i>Plan</i>	See <i>Tufts Health Plan</i> .
Plan Hospital	See <i>Tufts Health Plan Hospital</i> .
Plan Provider	See <i>Tufts Health Plan Provider</i> .
Premium	The total monthly cost of Coverage, which the <i>Group Insurance Commission</i> pays to <i>Tufts Health Plan</i> .
Primary Care Provider (PCP)	The <i>Tufts Health Plan</i> physician, nurse practitioner, or physician assistant you have chosen from the <i>Directory of Health Care Providers</i> and who has an agreement with the <i>Plan</i> to provide primary care and to coordinate, arrange, and authorize the provision of <i>Covered Services</i> .

Terms and Definitions, Continued

Term	Definition
Provider	<p>A health care professional or facility licensed in accordance with applicable state law, including, but not limited to, hospitals, limited service medical clinics, urgent care centers, physicians, physician assistants, doctors of osteopathy, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses certified as clinical specialists in psychiatric and mental health nursing, licensed alcohol and drug counselor I, licensed speech-language pathologists, and licensed audiologists.</p> <p>The <i>Plan</i> will only cover services of a <i>Provider</i> if those services are listed as <i>Covered Services</i> and within the scope of the <i>Provider's</i> license.</p> <p>Notes: For the purposes of alcohol use disorder:</p> <ul style="list-style-type: none"> • <i>Outpatient Provider</i> refers to an accredited or licensed hospital, or any public or private facility (or portion of that facility), that provides services especially for the rehabilitation of intoxicated persons or alcoholics and is licensed by the Massachusetts Department of Public Health or other applicable state law. <p><i>Inpatient Provider</i> refers to an accredited or licensed hospital, or any public or private facility (or portion of that facility), that (1) provides services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and is licensed by the Massachusetts Department of Public Health; or (2) is defined as a residential alcohol treatment program under Massachusetts law or other applicable state law.</p>
Provider Unit	<p>A <i>Provider Unit</i> is comprised of doctors and other health care <i>Providers</i> who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.</p>

Terms and Definitions, Continued

Term	Definition
Reasonable Charge	<p>The lesser of the:</p> <ul style="list-style-type: none"> • Amount charged; or • Amount that the <i>Plan</i> determines to be the reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.
Reserve Days	<p>The 60 days that Medicare will cover if you are hospitalized for more than 90 days of Medicare <i>Covered Services</i>. Medicare pays all covered costs for <i>Reserve Days</i>, except for a daily <i>Coinsurance</i> amount. These 60 <i>Reserve Days</i> can be used only once during your lifetime.</p>
Service Area	<p>The geographical area within which the <i>Plan</i> has developed a network of <i>Providers</i> to give <i>Members</i> adequate access to <i>Covered Services</i>. The Enrollment <i>Service Area</i> consists of the Standard <i>Service Area</i> and the Extended <i>Service Area</i>.</p> <p>The Standard <i>Service Area</i> is comprised of:</p> <ul style="list-style-type: none"> • All of Massachusetts; and • All of Rhode Island, except Block Island; and • The cities and towns in New Hampshire <ul style="list-style-type: none"> ○ In which <i>Plan PCPs</i> and specialists are located, and ○ Which are a reasonable distance from <i>Plan</i> specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs. <p>The Extended <i>Service Area</i> includes certain towns in Connecticut, New Hampshire, New York and Vermont which:</p> <ul style="list-style-type: none"> ○ Surround the Standard <i>Service Area</i>; and ○ Are within a reasonable distance from <i>Plan PCPs and</i> specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs. <p>Notes:</p> <ul style="list-style-type: none"> • There are generally no <i>Plan PCPs</i> located within the Extended <i>Service Area</i>. • For a list of cities and towns in the <i>Service Area</i>, call Member Services at 800-870-9488 or visit tuftshealthplan.com.

Terms and Definitions, Continued

Term	Definition
Skilled	A type of care, which is <i>Medically Necessary</i> and must be provided by, or under the direct supervision of, licensed medical personnel. <i>Skilled</i> care is provided to achieve a medically desired and realistically achievable outcome.
Spouse	The <i>Subscriber's</i> legal spouse, according to the law of the state in which you reside.
Subscriber	The person who: <ul style="list-style-type: none"> • Is a Medicare-eligible retired employee or a Medicare-eligible surviving spouse of a retired employee of the Commonwealth of Massachusetts or a <i>Participating Municipality</i>; • Enrolls in this plan and signs the membership application form on behalf of himself or herself; and • In whose name the <i>Premium</i> is paid.
Tobacco Cessation Counselor	<i>Providers</i> who are not physicians but who have completed at least eight (8) hours of instruction in tobacco cessation from an accredited institute of higher learning. Tobacco cessation counselors must work under the supervision of a physician.
Tufts Health Plan, Tufts HP, or the <i>Plan</i>	Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a <i>Tufts Health Plan</i> . <i>Tufts Health Plan</i> is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as “the <i>Plan</i> .”
Tufts Health Plan Hospital or Plan Hospital	A hospital that has an agreement with <i>Tufts Health Plan</i> to provide certain <i>Covered Services</i> to <i>Members</i> . <i>Plan Hospitals</i> are independent. They are not owned by <i>Tufts Health Plan</i> . <i>Plan Hospitals</i> are not agents, representatives, or employees of <i>Tufts Health Plan</i> .
Tufts Health Plan Provider or Plan Provider	A <i>Provider</i> with which <i>Tufts Health Plan</i> has an agreement to provide <i>Covered Services</i> to <i>Members</i> . <i>Providers</i> are not employees, agents or representatives of <i>Tufts Health Plan</i> .
Urgent Care	Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which <i>Urgent Care</i> might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection. Note: Care provided after the <i>Urgent</i> condition has been treated and stabilized and the <i>Member</i> is safe for transport is not considered <i>Urgent Care</i> .
Usual and Customary Charge	See “ <i>Reasonable Charge</i> .”

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2016 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter or if a generic version of a drug becomes available.

IMPORTANT NOTE: Please see our Web site at www.tuftshealthplan.com for the most current list or call a Member Specialist.

Brand Name	Suggested Alternatives
Acanya	clindamycin gel + benzoyl peroxide gel
Accu-Chek test strips	OneTouch
Accuretic	quinapril/hydrochlorothiazide tablets
AcipHex	Prilosec OTC (OTC, not covered), lansoprazole, omeprazole, pantoprazole
Acticlate	doxycycline tablets
Actiq	fentanyl lollipop
Acuvail	diclofenac eye drops, ketorolac eye drops
Aczone	benzoyl peroxide gel
Aerospan	Flovent HFA, QVar
Afrezza	Humalog
Alcortin A Topical Gel	hydrocortisone/iodoquinal cream
Aldactazide	spironolactone/hydrochlorothiazide
Aldactone	spironolactone
Altace	amipril
Altoprev	lovastatin tablets
Aluvea	urea cream
Alvesco	Flovent HFA, QVar
Ambien	zolpidem tartrate tablets
Ambien CR	zolpidem tartrate tablets, zolpidem extended-release
Amrix	cyclobenzaprine tablets
Anafranil	clomipramine
Analpram E Rectal Kit	hydrocortisone/pramoxine rectal cream
Anaprox/Anaprox DS	naproxen
Antara	fenofibrate
Apidra/Apidra Solostar	Humalog, Humulin
Apop gel 10%	sulfacetamide sodium with sulfur
Aptensio XR	Methylphenidate HCl ER
Arcapta Neohaler	Serevent Diskus, Perforomist
Asmanex	Flovent HFA, QVar
Astagraf XL	tacrolimus
Atacand	eprosartan, irbesartan, losartan
Atacand HCT	losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, candesartan/hydrochlorothiazide
Atelvia	alendronate
Ativan	lorazepam
Aurax Otic Solution	antipyrine 5.4%/benzocaine 5.4%
Avalide	irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Avandamet	Janumet, Kombiglyze XR, pioglitazone + metformin
Avandaryl	Januvia + glimepiride, pioglitazone + glimepiride
Avandia	Januvia, Onglyza, pioglitazone
Avapro	eprosartan, irbesartan, losartan
Avar/Avar LS	sulfacetamide sodium w/sulfur
Avelox	ciprofloxacin, levofloxacin
Axiron Solution	Androderm, Androgel
Beconase AQ	fluticasone nasal spray, flunisolide nasal spray, Nasonex
BenzE Foam	benzoyl peroxide (OTC, not covered)
BenzE Foam Ultra	<i>benzoyl peroxide (OTC, not covered)</i>
Bepreve	azelastine eye drops, cromolyn sodium eye drops
Binosto	alendronate, ibandronate
Brintellix	citalopram, fluoxetine, paroxetine
Brisdelle	estradiol, paroxetine 10 mg
Bydureon	Trulicity
Byetta	Victoza
Calan	verapamil
Calan SR	verapamil extended-release
Cambia	diclofenac potassium tablets
Caphosol	saliva substitute (OTC, not covered)
Cardizem	diltiazem
Cardizem CD	diltiazem extended-release
Cardizem LA	diltiazem extended-release
Cataflam	diclofenac
Catapres	clonidine
Catapres TTS	clonidine patch
Celexa	citalopram
Chenodal	ursodiol
Clobex spray	clobetasol lotion
Colestid	colestipol
Conzip	tramadol, tramadol extended-release
Coreg CR	carvedilol tablets
Cozaar	losartan
Cuvposa Solution	glycopyrrolate tablets
Daypro	oxaprozin
Desonate	desonide cream/lotion
Desoxyn	methamphetamine, amphetamine salts
Dexedrine Spansule	dextroamphetamine extended-release
Dexilant	Prilosec OTC, omeprazole, lansoprazole, pantoprazole
Diabetic Test Strips	OneTouch test strips
Diclegis	Unisom Sleep Tabs (OTC, not covered) and Vitamin B6 (OTC, not covered)
Dilacor XR	diltiazem extended-release
Dilaudid	hydromorphone

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Duexis	Ibuprofen 600-800 mg + famotidine OTC (OTC, not covered)
Dulera	Advair, Symbicort
Duragesic	fentanyl patch
Durezol	diclofenac eye drops, prednisolone acetate eye drops
Dymista	fluticasone nasal spray + azelastine nasal spray
Dynacin	minocycline
Ecoza 1%	econazole
Edarbi	eprosartan, irbesartan, losartan
Edarbyclor	irbesartan/hydrochlorozide, losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide
Edluar	zolpidem tartrate tablets
Effexor XR	venlafaxine extended-release
Elenzapatch	lidocaine patch
Epiduo	adapalene 0.1% gel + benzoyl peroxide 2.5% gel
esomeprazole strontium	omeprazole, pantoprazole
Exalgo	hydromorphone tablets
Extavia	betaseron
Extina foam 2%	ketoconazole foam
Factive	ciprofloxacin, levofloxacin, ofloxacin
Fanapt	olanzapine, quetiapine, risperidone
Fanatrex	gabapentin solution
Farxiga	Invokana
Fenoglide	fenofibrate tablets or capsules
Fentanyl 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	fentanyl 12, 25, 50, 75, 100 mcg/hr
Fentora	fentanyl citrate lollipop
Fetzima	citalopram, sertraline
Fexmid	cyclobenzaprine tablets
Fibricor	fenofibric acid tablets or capsules
Fioricet	butalbital/acetaminophen/caffeine
Fioricet with Codeine	butalbital/acetaminophen/caffeine/codeine 50 mg/325 mg/40 mg/30 mg
Fiorinal	butalbital/aspirin/caffeine
Flagyl 375mg	metronidazole 375 mg
Flagyl ER	metronidazole tablets
Flector	diclofenac tablets, Pennsaid, Voltaren gel
Flo-Pred	prednisolone 15 mg/5mL solution
Focalin	dexmethylphenidate
Fortamet	metformin extended-release tablets
Fortesta Gel	Androderm, Androgel
Fosamax	alendronate
Fosamax Plus D	alendronate + Vitamin D (Vitamin D is OTC, not covered)
Genotropin SP	Norditropin Nordiflex, Norditropin Flexpro
Giazo	balsalazide disodium

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Glumetza	metformin extended-release tablets
Glycate	gycopyrrolate
Gralise	gabapentin
Halcion	triazolam
Harvoni	Viekira Pak
Hemangeol	propranolol oral solution
Humatrope SP	Norditropin Nordiflex, Norditropin Flexpro
Hydro 35/Hydro 40	urea lotion, urea cream
Hysingla ER	hydrocodone/APAP
Hyzaar	losartan/hydrochlorothiazide
Incruse Ellipta	Spiriva
Inderal LA	propranolol extended-release
Inova	benzoyl peroxide wash (OTC, not covered), Stridex (OTC, not covered)
Invega	olanzapine, quetiapine, risperidone
Iprivask	enoxaparin, fondaparinux sodium
Irenka	duloxetine 20, 30, 60 mg
Jublia	ciclopirox topical solution
Karbinal ER	carbonoxamine
Kazano	Janumet, Jentadueto
Keppra XR	levetiracetam, levetiracetam extended-release
Kerafoam	urea lotion/cream
Kerydin	terbinafine tablets
Klonopin	clonazepam tablets
Kombiglyze XR	Janumet XR, Jentadueto
Lastacraft	azelastine, epinastine
Lescol	atorvastatin, fluvastatin, simvastatin
Lescol XL	atorvastatin, fluvastatin, simvastatin
Levaquin	ciprofloxacin, levofloxacin
Levemir	Lantus, Toujeo
Librax	chlordiazepoxide/clidinium
Lipitor	atorvastatin
Lipofen	fenofibrate
Liptruzet	atorvastatin
Livalo	atorvastatin, fluvastatin, simvastatin
Lofibra	fenofibrate
Lopid	gemfibrozil
Lopressor	metoprolol tartrate
Lorzone	chlorzoxazone
Lotensin HCT	benazepril/hydrochlorothiazide tablets

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Lotrel	amlodipine/benazepril
Lovaza	omega-3 fish oil (OTC, not covered)
Luvox CR	fluvoxamine tablets
Luzu	ketoconazole, econazole
Megace ES	megestrol acetate oral suspension
Mevacor	lovastatin tablets
Micardis	irbesartan, losartan, valsartan
Micardis HCT	irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide
Minocin	minocycline capsules
Mitigare 0.6 mg	cochicine
Monodox	doxycycline monohydrate
Moxatag	amoxicillin 500 mg, amoxicillin 875 mg
MS Contin	morphine sulfate extended-release
Namzarcic	Namenda XR, donepezil
Naprelan	naproxen sodium extended-release tablets
Naprosyn	naproxen
Natesto	testosterone gel
Nesina	Januvia, Tradjenta
Neutrasal	saliva substitute (OTC, not covered)
Nexium	lansoprazole, omeprazole, pantoprazole, Prilosec OTC. Nexium oral packets are covered for <i>Members</i> 12 years of age or younger. Quantity limitations apply.
Norco	hydrocodone/acetaminophen
Norpramin	desipramine
Norvasc	amlodipine
Novolin, Novolog	Humulin, Humalog
Noxafil	fluconazole oral suspension, itraconazole, voriconazole
Nucynta	oxycodone, tramadol
Nucynta ER	tramadol, Oxycontin
Nutropin AQ Nuspin SP	Norditropin Nordiflex, Norditropin Flexpro
Nutropin AQ SP	Norditropin Nordiflex, Norditropin Flexpro
Nutropin SP	Norditropin Nordiflex, Norditropin Flexpro
Olux-E	clobetasol 0.05% foam, clobetasol 0.05% foam/emollient
Olysio	Viekira Pak
Omeclamox-Pak	omeprazole + clarithromycin + amoxicillin, PrevPac
Omnitrope SP	Norditropin Nordiflex, Norditropin Flexpro
Onexton Gel	clindamycin/benzoyl peroxide 1/5%
Onglyza	Januvia
Opana	oxymorphone, hydromorphone tablets, oxycodone tablets
Opana ER	morphine sulfate SR, oxymorphone extended release
Oracea	doxycycline
Oravig	fluconazole
Oseni	Januvia, Tradjenta

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Oxecta 5 mg, 7.5 mg	oxycodone
Oxytrol	oxybutynin
Pacnex HP	benzoyl peroxide pad
Pacnex LP	benzoyl peroxide pad
Pacnex MX	benzoyl peroxide (OTC, not covered)
Pamelor	nortriptyline
Parnate	tranlycypromine
Patanase	azelastine nasal spray, Astepro
Paxil	paroxetine
Paxil CR	paroxetine, paroxetine extended-release
Pepcid (except suspension)	cimetidine, famotidine, ranitidine
Percocet	oxycodone/acetaminophen
Percodan	oxycodone/aspirin
Pliaglis	lidocaine/prilocaine cream
Pravachol	pravastatin tablets
Prestalia	Perindopril, amlodopine
Prevacid	lansoprazole, omeprazole, pantoprazole, Prilosec OTC (OTC, not covered)
Prevacid Solutab	lansoprazole, omeprazole, pantoprazole, Prilosec OTC. Prevacid Solutab and generic lansoprazole soluble tablets are covered for <i>Members</i> 12 years of age and younger. Quantity limitations apply.
Prilosec	Prilosec OTC (OTC, not covered), omeprazole, lansoprazole, pantoprazole
Prilosec Oral Suspension	omeprazole, lansoprazole, pantoprazole. Prilosec Oral Suspension is covered for <i>Members</i> 12 years of age and younger.
Procardia XL	nifedipine extended-release
Procort	hydrocortisone/pramoxine cream
Procysbi	Cystagon
Proscar	finasteride 5mg
Protonix	Prilosec OTC (OTC, not covered), lansoprazole, omeprazole, pantoprazole
Protonix Oral Suspension	lansoprazole, omeprazole, pantoprazole. Protonix Oral Suspension is covered for <i>Members</i> 12 years of age and younger. Quantity limitations apply.
Provigil	modafinil, Nuvigil
Prozac	fluoxetine
Prozac Weekly	fluoxetine, fluoxetine delayed-release
Pulmicort Flexhaler	Flovent HFA, QVar
Qnasl	fluticasone nasal spray, flunisolide nasal spray, Nasonex
Qudexy XR	topiramate extended-release
Questran/Questran Light	cholestyramine
Rapaflo	alfuzosin extended-release, doxazosin, tamsulosin

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Rayos	prednisone
Restoril	temazepam
Rexaphenac Cream	diclofenac sodium
Riax	benzoyl peroxide
Roxicodone	oxycodone
Rytary	carbidopa/levodopa
Saizen SP	Norditropin Nordiflex, Norditropin Flexpro
Salkera Foam	salicylic acid cream, foam, or lotion
Salvax 6% Foam	salicylic acid cream, foam, or lotion
Salvax Duo Plus Combo Pack	salicylic acid lotion + urea lotion
Saphris	olanzapine, quetiapine, risperidone
Sectral	acebutolol
SelRx	selenium sulfide shampoo
Silenor	rozerem, zaleplon, zolpidem
Sitavig	acyclovir
Skelaxin	cyclobenzaprine, dantrolene, tizanidine
Solodyn	minocycline extended-release
Soma 250 mg	carisoprodol tablets
Sonata	zaleplon
Sorilux	calcipotriene topical solution, cream, or ointment
Sprix	ketolorac
Sular	amlodipine, felodipine, nisoldipine extended-release
Sumadan	sodium sulfacetamide/sulfur wash
Sumaxin TS	sodium sulfacetamide/sulfur 10/5%
Sumaxin	sulfacetamide sodium 10% + sulfur 5% Med Pads
Symbicort	Advair
Taclonex	betamethasone dipropionate + calcipotriene ointment
Taclonex Scalp	betamethasone dipropionate + calcipotriene solution
Tenex	guanfacine
Tenormin	atenolol
Tenoretic	atenolol/chlorthalidone
Tersi Foam	selenium sulfide shampoo
Teveten	eprosartan, irbesartan, losartan
Teveten HCT	irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide
Tev-Tropin SP	Norditropin Nordiflex, Norditropin Flexpro
Tiazac	diltiazem extended-release
Tivorbex	indomethacin
Tofranil	imipramine
Topicort Spray 0.25%	desoximetasone 0.25%
Toviaz	oxybutynin ER, trospium
Tranxene T-Tab	clorazepate
Treximet	sumatriptan + naproxen sodium
Trezix	butalbital/APAP/codeine
Tribenzor	Benicar, amlodipine, hydrochlorothiazide

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Tricor	fenofibrate
Triglide	fenofibrate
Trilipix	fenofibrate
TriOxin	MyOxin
Trokendi XR	topiramate
Twynsta	amlodipine + ARB, Azor, Exforge
Tylenol with Codeine	acetaminophen/codeine
Ultracet	tramadol/acetaminophen
Ultram	tramadol
Ultram ER	tramadol, tramadol extended-release
Ultravate X	halobetasol + lactic acid cream
Umecta PD	urea lotion or cream
Uramaxin	urea cream, gel or lotion
Utopic	urea cream
Valium	diazepam tablets
Vascepa	omega-3 fish oil
Vectical	calcitriol ointment
Veltin Gel	clindamycin + tretinoin gel
Veramyst	fluticasone propionate nasal spray, flunisolide nasal spray, Nasonex
Verdeso	desonide cream/lotion
Veregen	imiquimod, podofilox, Condylox
Verelan	verapamil extended-release
Verelan/PM	verapamil extended-release
Vicoprofen	hydrocodone/ibuprofen tablets
Vitreolis	Viekira Pak
Vimovo	naproxen + omeprazole
Virasal	salicylic acid (OTC, not covered)
Vusion	miconazole nitrate & zinc oxide (OTC, not covered)
Vytone	dermazene/iodoquinol
Wellbutrin	bupropion
Wellbutrin SR	bupropion extended-release or bupropion SR
Wellbutrin XL	bupropion XL
Xalatan	latanoprost
Xanax	alprazolam tablets
Xanax XR	alprazolam extended-release tablets
Xerese Cream 5-1%	Denavir, Zorivax
Xigduo XR	Invokamet
Xolegel	ketoconazole cream
Zegerid capsules	Prilosec OTC (OTC, not covered), lansoprazole, omeprazole, omeprazole/sodium bicarbonate, pantoprazole
Zegerid oral packets	Prilosec OTC (OTC, not covered), lansoprazole, omeprazole, omeprazole/sodium bicarbonate, pantoprazole. Zegerid oral packets are covered for <i>Members</i> 12 years and younger.

Appendix B – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Zelapar	selegiline tablets
Zenzedi	dextroamphetamine sulfate tablets
Zetonna	fluticasone nasal spray, flunisolide nasal spray, triamcinolone nasal spray
Ziana	tretinoin gel + clindamycin gel
Zipsor	diclofenac tablets
Zithranol	calcipotriene solution
Zithranol-RR	Drithocrema HP
Zocor	simvastatin tablets
Zofran	ondansetron
Zohydro ER	hydrocodone/acetaminophen
Zoloft	sertraline
Zomacton	Norditropin FlexPro, Norditropin Nordiflex
Zorvolex	diclofenac potassium, diclofenac sodium
Zyflo CR	zafirlukast
Zymaxid	ciprofloxacin drugs

**GROUP INSURANCE COMMISSION NOTICES
FOR SUBSCRIBERS
ENROLLED IN TUFTS MEDICARE
COMPLEMENT (TMC) PLAN**

The Commonwealth of Massachusetts Group Insurance Commission

P.O. Box 8747
Boston, MA 02114



Phone (617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

This notice explains COBRA and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment; (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the GIC's health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete and return the GIC COBRA Election Form no later than 60 days after your group coverage ends. You may send it to the GIC's Public Information Unit at P.O. Box 8747, Boston, MA 02114 or hand deliver it to the GIC at 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or a municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;

- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid *in full* when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after your GIC coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA coverage cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.**

Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, you may purchase health insurance through the Commonwealth's Health Connector Authority or through the Health Insurance Marketplace in other states. The GIC has no involvement in conversion programs or the Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA coverage responsibilities:

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
 - The employee's job terminates or his/her hours are reduced;
 - The insured dies;
 - The insured becomes legally separated or divorced;
 - The insured or insured's former spouse remarries;
 - A covered child ceases to be a dependent under GIC eligibility rules;
 - The Social Security Administration determines that the employee or a covered family member is disabled; or
 - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P.O. Box 8747, Boston, MA 02114.

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 866-444-3272 or dol.gov/ebsa. For more information about health insurance options available through a Health Insurance Marketplace, visit healthcare.gov or, in Massachusetts, visit mahealthconnector.org.

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

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FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS.
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There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare Part D drug plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a non-GIC Medicare drug plan.

What happens to your current coverage if you decide to join a non-GIC Medicare drug plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at [socialsecurity.gov](https://www.socialsecurity.gov) or by phone at 800-772-1213 (TTY: 800-325-0778).

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage ...

Contact the GIC at 617-727-2310, ext. 1.

Note: You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **socialsecurity.gov** or call 800-772-1213 (TTY: 800-325-0778).

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Remember: Keep this Creditable Coverage notice. If you decide to join on of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
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THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866-4-USA-DOL** or visit its website at **dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at 617-727-2310, ext. 1.

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party “Business Associates” that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can

perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310, ext. 1 or TTY for the deaf and hard of hearing at 617-227-8583.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor electronically at **askebsa.dol.gov** or call **866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. Contact your State for further information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: myalhipp.com Phone: 855-692-5447	Website: dch.georgia.gov Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 800-869-1150
ALASKA – Medicaid	INDIANA – Medicaid
Website: health.hss.state.ak.us/dpa/programs/medicaid Phone (Outside of Anchorage): 888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: hip.in.gov Phone: 877-438-4479 All other Medicaid Website: indianamedicaid.com Phone 800-403-0964

COLORADO – Medicaid	
Medicaid Website: colorado.gov/hcpf Medicaid Customer Contact Center: 800-221-3943	
FLORIDA – Medicaid	MONTANA – Medicaid
Website: myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid Phone: 866-762-2237	Website: medicaid.mt.gov/member Phone: 800-694-3084
IOWA – Medicaid	NEBRASKA – Medicaid
Website: dhs.state.ia.us/hipp Phone: 888-346-9562	Website: dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 855-632-7633
KANSAS – Medicaid	NEVADA – Medicaid
Website: kdheks.gov/hcf Phone: 785-296-3512	Website: dwss.nv.gov Phone: 800-992-0900
KENTUCKY – Medicaid	
Website: chfs.ky.gov/dms/default.htm Phone: 800-635-2570	
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888-695-2447	Website: dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 800-852-3345, ext. 8763

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: maine.gov/dhhs/ofc/public-assistance/index.html Phone: 800-442-6003 TTY Maine relay 711	Website: njfamilycare.org/index.html CHIP Phone: 800-701-0710
MASSACHUSETTS – Medicaid and CHIP	
Website: mass.gov/MassHealth Phone: 800-462-1120	NEW YORK – Medicaid
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 800-657-3739	Website: http://nyhealth.gov/health_care/medicaid Phone: 800-542831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-522-2326	Website: ncdhhs.gov/dma Phone: 919-855-4100
OKLAHOMA – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: insureoklahoma.org Phone: 888-365-3742	Website: nd.gov/dhs/services/medicalserv/medicaid Phone: 844-854-4825

OREGON – Medicaid	UTAH – Medicaid and CHIP
Website: oregonhealthykids.gov hijosaludablesoregon.gov Phone: 800-699-9075	Website: Medicaid: health.utah.gov/medicaid CHIP: health.utah.gov/chip Phone: 877-543-7669
PENNSYLVANIA – Medicaid	VERMONT– Medicaid
Website: dhs.pa.gov/hipp Phone: 800-692-7462	Website: greenmountaincare.org Phone: 800-250-8427
RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/HealthcareOverview.aspx Phone: 401-462-5300	Medicaid Website: coverva.org/programs_premuim_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Website: coverva.org/programs_premium_assistance.cfm CHIP Phone: 855-242-8282
SOUTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: scdhhs.gov Phone: 888-549-0820	Website: hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 800-562-3022, ext. 15473
SOUTH DAKOTA - Medicaid	WEST VIRGINIA – Medicaid
Website: dss.sd.gov Phone: 888-828-0059	Website: dhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	WISCONSIN – Medicaid and CHIP
Website: gethipptexas.com Phone: 800-440-0493	Website: dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800-362-3002
	WYOMING – Medicaid
	Website: wyequalitycare.acs-inc.com Phone: 307-777-7531

To see if any other States have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you and/or your family members. For information on how to select a *Primary Care Provider*, and for a list of the participating *Primary Care Providers*, contact Member Services or visit tuftshealthplan.com.

For *Children*, you may designate a pediatrician as the *Primary Care Provider*.

You do not need prior authorization from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or visit tuftshealthplan.com.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

800.870.9488



Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 800.870.9488

tuftshealthplan.com

Offered by Tufts Associated Health Maintenance Organization, Inc.